Year 2000 HIV Prevention Plan Update for Hawai#i

and
1998-1999 Community Planning Progress Report

September 1999

Hawai#i HIV Prevention Community Planning Group

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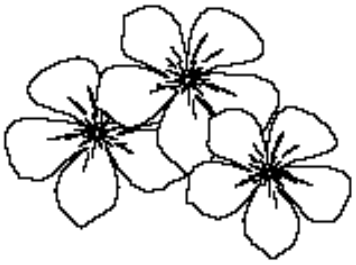

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Year 2000 HIV Prevention Plan Update for Hawai#i

and 1998-1999 Community Planning Progress Report

(September 1999)

Introduction

This plan is an update of the HIV Prevention Plan for the State of Hawai#i for the year 2000. It includes a report of progress made in the last six months of 1998 and the first seven months of 1999. The plan lists the recommendations, objectives, strategies and interventions approved by the Hawai#i HIV Prevention Community Planning Group for the year 2000. The update can be used in conjunction with the *1999 HIV Prevention Plan Update for the State of Hawai#i* (which contains a description of the latest priority groups and strategies and interventions that will be in effect for the year 2000).

Executive summary

This document represents the work of community planning from July 1998 through July 1999: the progress, plans, and recommendations. The Hawai#i HIV Prevention Community Planning Group is a diverse group representing populations at risk for HIV, geographic areas, and various ethnic and racial populations in Hawai#i. The Hawai#i HIV Prevention Community Planning Group was established five years ago to provide a forum for individuals with or affected by HIV, those providing AIDS-related services, interested community members, and Department of Health staff to work in partnership to plan prevention services for Hawai#i. PCPG members review available information about needs and HIV, prioritize HIV prevention needs, assess community resources to address the HIV epidemic, identify unmet HIV prevention needs, and provide input into a statewide HIV prevention plan. The *1999 HIV Prevention Plan Update for the State of Hawai#i* is available on the Internet, thanks to a PCPG member.

This year there has been a refinement of last year's efforts to orient new members. Additional orientation and technical assistance sessions (on evaluation, needs assessment, epidemiology, counseling and testing, etc.) were added. The group approved planning calendars for 1999 and 2000 to facilitate a smoother planning process. The majority of the work of the PCPG continues to be done through committees.

Two areas that received extra attention in the past year and resulted in substantial recommendations for

the year 2000 are counseling and testing and needs assessment. This plan contains a large section on counseling and testing. The first part reports on the progress on the recommendations made last year by an active Counseling and Testing Committee. Last fall, an advisory group was formed by the STD/AIDS Prevention Branch (SAPB) chief to develop a strategic plan for counseling and testing. Various PCPG members were members of this advisory group. The advisory group's recommendations were later approved by the PCPG.
As a result, systems are being developed to provide counseling and testing results by phone and to provide preliminary results which allow people to get quicker results.

A needs assessment study of Asian and Pacific Island gay and bisexual men and HIV risk in Hawai#i was completed in the last year by Val Kanuha, Ph.D. The findings and recommendations from her report are included in this plan. The PCPG encourages continued consideration of these findings in order to shape more effective HIV prevention efforts for local populations.

Community planning

Progress and accomplishments (July 1998 - June 1999)

Committees
For the second year, the majority of work of the Hawai#i HIV Prevention Community Planning Group (PCPG) is taking place at the committee level. In 1997 - 1998, we developed a committee structure to accomplish the majority of the work of community planning. Committee members are current and former PCPG members, and other interested individuals. Consideration of issues takes place at the committee level. Minutes of all meetings are distributed to PCPG members and committee reports are given at PCPG meetings. Final approval of a committee's recommendations rests with the PCPG. At times, the PCPG as a whole has modified recommendations made by a committee. Occasionally, the PCPG has recommended that an issue needs further discussion at the committee level. The process seems to be working well. Members feel satisfied that they are accomplishing the tasks set before them. PCPG members being involved in the work of the committees improves parity and inclusion.

The most active committees of the PCPG in the last year were Membership, Needs Assessment, Steering and Evaluation Committees. New committees in 1999 are the Bylaws Subcommittee and the Committee to Strengthen Linkages between Primary and Secondary Prevention. The Counseling and Testing Committee was active through November 1998 and then did not meet since many of the same members were on the Counseling and Testing Community Advisory Group convened by the SAPB branch chief. This year a few people joined the Newsletter Committee. The Prioritization Task Force has not met since October 1998 when they helped decide a state-funded program issue. The Budget Committee met twice in July 1998, once in spring 1999, and by conference call in July 1999 to review the 2000 proposed budget for the CDC application. More information about these committees is in the following sections:

Committee --	***Section of this plan***
Membership Committee --	Community planning

Bylaws Subcommittee --	Community planning
Steering Committee --	Community planning
Budget Committee --	Community planning
Needs Assessment Committee --	Needs assessment
Counseling and Testing Committee --	Counseling and testing
Evaluation Committee --	Evaluation
Committee to Strengthen Linkages between Primary and Secondary Prevention —	Linkages

Prevention Community Planning Group

The 1999 Hawai#i HIV Prevention Community Planning Group (PCPG) is composed of 25 members. The group includes representatives from five islands. Four of the members are HIV positive; 12 are gay men, two are transgender, one is lesbian, 10 are heterosexual (8 females and 2 heterosexual males), 14 are male and 9 are female and 2 transgendered (TG) individuals; 15 are Asian/ Pacific Islander (A/PI), 8 are white, 1 is Hispanic, 1 is African American. Ethnicities of A/PI members include 7 Hawaiian, 6 Filipino, 4 Japanese, and 4 Chinese. Many members are of mixed heritage. There are 9 gay men of color and six women of color and 2 transgendered individuals of color. There are members who work for the Department of Education, corrections, and mental health services and with the populations of intravenous drug users and with women at risk for HIV. There are only four community members who are not employed with organizations that provide HIV prevention. See community planning membership grid in the appendix for more information about PCPG members.

Statewide recruitment efforts for new members for 1999 included press releases sent to newspapers statewide. Other efforts included placing recruitment information in the statewide joint care and HIV prevention community planning newsletter, as well as announcements at HIV meetings on the various islands. The newsletter is sent out by the STD/AIDS Prevention Branch and through several of the AIDS service organizations. Candidates applied for the various vacancies, and the new members for 1999 were elected by last year's PCPG in December 1998. There were eight more candidates than there were available positions. The unelected candidates were invited to join committees. The PCPG's bylaws limit the PCPG to 25 members.

The PCPG continues to have designated representatives for specific geographic areas as well as positions for high-risk populations and areas of expertise. For the year 2000 through 2001, the PCPG has approved the following available positions for recruitment: East Hawai#i, Maui, Moloka#i, Kaua#i, rural O#ahu, mental health (services), Hawaiians, youth at-risk (age 14-21), and at-large (anyone). Recruitment materials are being distributed in July 1999 and state the following: "All interested people are welcome to apply. Those with the following backgrounds are especially encouraged to apply: gay men, HIV positive individuals, bisexual males, youth at risk, women at risk, past or present substance (injection drug) users, and those working in the fields of injection drug use, behavioral science, HIV/AIDS, or epidemiology." Also two appointed positions will continue in the year 2000 -- the representatives from the Department of Education and from the statewide consortium of AIDS service providers, AIDS Community Care Team. The PCPG approved the recommendation to offer an incentive for participation for the youth at-risk position, if the selected person is in need, since young people have less access to resources.

To improve parity, so that all members would be equally prepared to fully participate in the process, various efforts were taken to orient new members. The first meeting of the year was an orientation meeting. Continuing members assisted with the preparation and presentation of the orientation. The orientation manual that was developed for 1998 was updated and distributed to all new members. The manual contains three sections: 1) Guidance -- groundrules and bylaws, the CDC guidance for community planning, roles of those involved in community planning; 2) The most recent "epi" profile and prevention plan update for Hawai#i; 3) Program information such as a list of state and federally funded programs in Hawai#i, SAPB organization chart, planning/contracting timeline and information on behavioral science theory and harm reduction. At other PCPG meetings, we provided additional orientation sessions. An overview of the progress of each committee (Membership, Evaluation, etc.) was introduced at the orientation, but feedback indicates that we need to do a more in-depth orientation about committees for new committee members. At the February 1999 meeting, two PCPG members provided an orientation about the harm reduction philosophy and stages of behavior change theory. Dr. Al Katz gave a basic overview of epidemiology and the "epi" profile at the March 1999 meeting. Dr. Chuck Mueller presented a needs assessment and evaluation orientation for the April 1999 PCPG meeting. We continued with the buddy system of pairing new members with experienced members who could answer questions and provide support to the new members.

Ten meetings were scheduled in 1999 as in 1998. The Membership Committee refined the procedure to encourage better attendance of members who have missed meetings. A recognition and appreciation session was held at the December 1999 meeting of the PCPG. Members with excellent PCPG meeting attendance records, co-chairs, and committee chairs received awards. All members received an appreciation from other members of the PCPG.

Community input

PCPG members completed a survey regarding how they share and receive information from the group or area they represent. PCPG members interact with a variety of organizations, at-risk populations, and other individuals. Members use various methods to share information about the work of the PCPG and to obtain input to bring back to the community planning process. The results of this survey follow.

PCPG members report that they share information and/or receive input from the following groups/constituents:

Health care provider organizations on Wai#anae Coast and in Ko#olauloa
Public health nurses; Home health services
GayMAP (workers doing HIV prevention with MSM)
ASO and other outreach workers; AIDS Educators' Quarterly
Staff, volunteers, clients of AIDS service organization on Kaua#i, Maui
Maui AIDS Related Services group; East Hawai#i AIDS Related Services group
American Red Cross of Kaua#i, O#ahu

Incarcerated persons; From people who are in or have been in KCCC
Corrections facility supervisors; Health care provider staff of corrections;
IDUs; Needle exchange outreach workers; Other outreach workers of organizations that serve IDU clients
Ko#olauloa Interagency and Community Council; Ko#olauloa Children's Community Council - special needs youth
HIV positive youth, adults, women, and clients
Community advisory committees (MSM, women, youth, Filipinos, Hawaiians, TGS)
Other community and state agencies (Commission on the Status of Women, DOE, Hawai#i State Hospital, Drug Addiction Services of Hawai#i (DASH), Alu Like)
ACCT
Care-a-Van
DOH counselor-testers; Diamond Head Health Center STD workers
CDC - Bernie Branson
Chocolates in Hawai#i; Sister-Sister; Black Nurses Coalition; Afro-American military dependents
Hawaiians; Ke Ola Mamo and its oversight committee
Filipino community members
Latinos
TGS
Sex industry workers; heterosexual male and female prostitutes
MSM
Youth
Women at risk coalition
Women in the domestic violence shelter in Honolulu
Homeless population (teens and adults), homeless shelters
Support services providers
Students, schools
Co-workers
General public; Friends; Anybody who will listen.

How PCPG members share information and/or get input:

From talking to folks
Internet; E-mail
Jim McNulty, PCPG member and Kaua#i representative, included the *1999 HIV Prevention Plan Update for the State of Hawai#i* on the website of Malama Pono, the ASO on Kaua#i.
Meetings
Talks in schools, classroom; Presentations in hospitals
Community meetings
Phone calls
Attendance and participation in meetings and through social events.
Conferences; trainings

Home visits
Mailing of PCPG newsletter
Mailouts to educators, Community advisory committees
Monthly meeting of East Hawai#i AIDS Related Services
Sharing copies of pertinent information with the groups; FAX
Reading literature
Consultation with other HIV/AIDS and A/PI researchers and providers
Media
Focus groups
Group and individual level interventions
Forming a community group to focus on primary and secondary prevention to gather information.
Street outreach; From venues frequented by my population; Direct community interaction
Personal experience

Bylaws
In 1998, the PCPG approved the recommendation to improve the PCPG bylaws and make them more explicit by 1999.
This process will take more than one year to complete. So far, a conflict of interest disclosure form was approved for all PCPG members to complete. Guidelines related to conflict of interest are still being discussed. The community planning evaluation survey asks members for their views about conflict of interest and the CPG, which will be considered in the development of guidelines.

2000 Recommendations for community planning

1. The approved planning calendar for 2000 follows this section.

2. One or two meetings might be on a neighbor island next year based on the results of the evaluation of this year's neighbor island meeting.

3. By July 2000, post the prevention plan on the websites of DOH and AIDS Service Organizations and create links between them.

4. Review community planning expenses for ways to economize and hold meetings at locations convenient to the airport for neighbor island members.
   Hold some committee meetings at PCPG meetings.
   Have some committee meetings by conference call to save time and expenses.

5. Provide an orientation to new committee members at the beginning of the year.
   Encourage new members to ask questions at meetings.

6. Continue updating the PCPG bylaws.

Year 2000 Planning Schedule

January

CPG meeting:
* Orientation

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Committees:
* Begin prioritization of groups

* Review draft evaluation plan

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DOH:
* 1999 "Epi" profile data available Jan 31.

February

CPG meeting:
* CAC presentations of recommendations for strategies and interventions (S & I)

* CPG members to review draft evaluation plan

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Committees:
* Committees work on recommendations for 2001

* Prioritization of groups

March

CPG meeting:
* CAC presentations of recommendations for S & I

* Vote and approve prioritization of groups

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Committees:
* Committees work on recommendations for 2001

* Review revised evaluation plan

* Begin prioritization of interventions

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DOH:
* 1999 progress report due to CDC

April

CPG meeting:
* Vote on and approve committee recommendations and evaluation plan

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Committees:
* Finish prioritization of interventions

Year 2000 Planning Schedule

May	June	July	August
CPG meeting: *Vote on and approve committee recommendations and prioritization of interventions *** All** 2001 recommendations approved for plan by May 19 ~~~ **DOH:** * Complete prevention plan	**CPG meeting:** * Complete final plan and approve by June 16 ~~~ **DOH:** * June 19 Begin grant application * Begin preparing federal budget	**CPG meeting:** * CPG review budget, support by July 21 ~~~ **Committees:** * Budget Committee meets to review proposed budget ~~~ **DOH:** * Write application * Complete federal budget *July 24 Write RFPs (if they are to be changed)	**CPG meeting:** ~~~ **DOH:** * Write RFPs * Complete grant application * Late August Release RFPs (if they are to be changed)
September	**October**	**November**	**December**
No CPG meeting ~~~ **DOH:** * Submit CDC grant application	**CPG meeting:** * Review planning year * Plan year 2001	**CPG meeting:** * Recognition of members	No CPG meeting

Evaluation of Community Planning

PCPG members were asked to evaluate each CPG meeting by completing a meeting evaluation form. The form usually asks two questions: "1. What did you like about today's meeting? and 2. What suggestions do you have to make these meetings better?" The community planning coordinator and the PCPG co-chairs reviewed the evaluations and discussed concerns that are raised.

In July 1999, a survey to evaluate the community planning process was given to PCPG members. As of September 11, 20 members of the PCPG completed the survey. Of the five that didn't complete the survey, two have recently resigned and one member has been less active. The data from the 26 scaled items are in the appendix. In addition, there were written comments. The only statement that 100% of the group agreed with was "community planning has influenced the allocation of resources."

Eighty or more percent of the group agreed with the following statements:

~ Received timely notice of meetings
~ Member should let the group know if they have conflict of interest when they are discussing an issue.
~ Committee structure is effective way to do the work of community planning.
~ Community planning has influenced allocation of resources
~ Minutes provide adequate information
~ I feel safe sharing thoughts at CPG meetings
~ Committee structure should continue next year
~ Technical assistance is useful to me as CPG member (evaluation, needs assessment, counseling and testing, "epi")
~ Committees are set up to encourage participation
~ CPG influences prevention programs
~ Prioritization based on available evidence
~ Received adequate orientation
~ Members listen to and are sensitive to differences
~ Meetings run efficiently by co-chair or facilitator
~ CPG reflects HIV epidemic in our planning area
~ Members understand their roles and responsibilities

Responses that showed less agreement suggest areas for improvement. Only 70% agreed with the statement: "Technical terms, concepts, and acronyms are clearly defined so that all CPG members understand." Only 45% agreed that "HIV funds have been distributed fairly." 65% of the group agreed that "CPG members have not used meetings to further own personal or organizational interests." Forty-five percent agreed that "conflict of interest has a negative effect on decisions made by the CPG." A number of written comments on the open-ended parts of the survey reflected the concern that a majority of the PCPG members were from organizations receiving HIV prevention funding, rather than from the community.

All 1999 mean scores were higher than 1997's. Twelve of the item mean scores were slightly higher in 1999 than 1998. Five item mean scores were the same in 1999 as in 1998. Three were slightly lower in 1999 than 1998 (from .1 to .4 of a point). The appendix includes a table of the 1997, 1998, and 1999 results for each survey statement as well as the actual survey instrument. A report of the survey results will be shared with the PCPG members. The Steering Committee and community planning coordinator will discuss these issues, review the written comments from the survey, solicit more information from the PCPG as appropriate, and create some strategies to address these issues in next year's planning cycle. These results may encourage efforts to ifmprove the planning process for next year. They also remind us about the different points of view represented by PCPG members.

Community planning evaluation plan

1. Members will have the opportunity to evaluate each PCPG meeting in 2000 by completing a meeting evaluation form. The community planning coordinator and the PCPG co-chairs will review the evaluations.

2. By July 1, 2000, a survey will be distributed to the PCPG members to evaluate the community planning process. The results will be analyzed for the grant application.

Technical assistance

Community Planning
Progress and accomplishments (July 1998 - June 1999)

Nine PCPG members plus the community planning coordinator attended the CPLOT in October 1998.

In February 1999, Bernie Branson, MD, resource person in counseling and testing from CDC, and Kevin O'Connor, Hawai#i's CDC project officer, provided technical assistance to the PCPG, SAPB, and contracted agencies. They presented at the February PCPG meeting and met with committees, staff, and community advisory groups. A more detailed account of their visit is given in the February 1999 PCPG minutes.

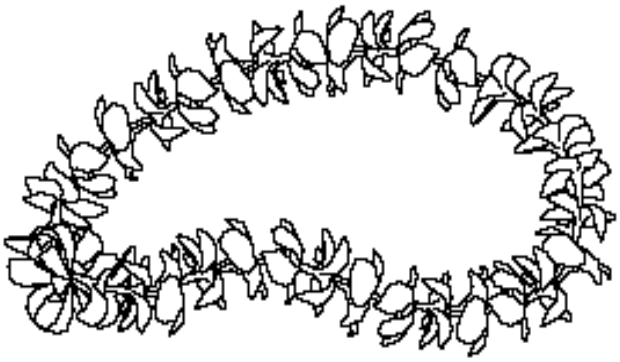
Kevin O'Connor emphasized the importance of providing prevention services for individuals already infected with HIV. Kevin discussed Partner Counseling and Referral Services (PCRS) which informs individuals that they have been exposed to HIV and provides the opportunity for testing and other services and treatment. Kevin spoke about some community planning issues, such as members sharing community planning information with the community and conflict of interest. He briefly reviewed the upcoming evaluation guidance. Kevin highlighted the review comments of Hawai#i's grant application and said that it was very favorably received.

Dr. Branson presented a lot of information from studies about counseling and testing practices and issues throughout the U.S. He also emphasized that before making policy decisions, it is important to ask the consumers their perspectives on potential changes in services. He spoke about various ways to improve return rates for test results and access to testing. He discussed rapid test technologies; separating counseling from testing, since not everyone needs the same level of counseling; the importance of client-centered counseling; and the need for training and quality assurance. Dr. Branson discussed "opt out" vs. "opt in" approaches to HIV testing. He also described studies of offering test results by phone; offering preliminary results; using home test kits. He also talked about knowledge of one's own and one's partner's HIV status to help decide if it is safe to have unprotected sex within a monogamous relationship with two people of same HIV status.

The January meeting was an orientation to community planning. At the February meeting, PCPG members Cesar Cadabes and Jim McNulty provided an orientation about the harm reduction philosophy and stages of behavior change theory. Dr. Al Katz gave a basic overview of epidemiology and the "epi" profile at the March 1999 meeting. Dr. Chuck Mueller presented a needs assessment and evaluation orientation for PCPG members at the April 1999 meeting.

At the March 1999 PCPG meeting, Dr. Val Kanuha reported her findings from the 1998 needs assessment project entitled *A needs assessment study of Asian and Pacific Island gay and bisexual men and HIV risk in Hawai#i.* Dr. Mueller presented reports at the March 1999 PCPG meeting of the evaluation studies of Life Foundation's outreach counseling and testing program and Ke Ola Mamo's survey of transgendered individuals. Dr. Sara Millman from Hilo presented the epidemiologic profile report to the PCPG at the June 1999 meeting. The profile described the limitations of each type of data used. The profile included 1998 data about AIDS, HSPAMM (HIV cases), the counseling and testing program, STDs, and ASO clients.

At the July 1999, PCPG meeting, Bryceton Danico and Laura Ellis from Safe Haven, a mental health services organization, gave information about how to approach and work with someone who is homeless and mentally ill. They presented tips on effective communication, as well as discussed referrals and barriers to linkages.



Technical assistance needs survey for community planning group members

A goal for community planning is for <u>all</u> PCPG members to be prepared to participate fully in the community planning process. A survey was distributed to all PCPG members asking them to prioritize their needs for technical assistance related to community planning. They were asked what would help them to do a better job of community planning. The

summary of the responses to the survey follows:

	Technical assistance needs	**# of people choosing item**	**Total points** [1]
1	Strategies to overcome barriers to prevention	14	53
2	Evaluation of HIV prevention programs	12	32
3	Cultural issues	8	27
4	Assessing community resources	9	24
5	Needs assessment of priority populations	6	22
6	Overview of current prevention programs	5	17
6	Strategies and interventions	5	17
7	Writing specific, measurable objectives	4	16
8	Identification of unmet needs	5	13
9	Behavioral and social science	5	12
10	Outreach	5	9
11	Setting priorities	3	8
11	Community planning	2	8
12	Conflict resolution	2	6
12	Training	2	6
13	Program planning	3	5
13	Use of “epi” data and other data	2	5
14	Harm reduction	2	4

The following comments about technical assistance needs were expressed on the survey or at the the June CPG meeting:

[1] Items were reverse-coded. The survey had 1 as highest priority. Responses of 1 were coded as 5 here.

Consensus building
Group facilitation
Public speaking
Conflict resolution
Orient new committee members to each committee
How to create safety to promote discussion
How to better use the money
Training in political strategy to compete for resources
Translating national and international research to local situation
Global perspective of HIV prevention
Incorporate Dr. Kanuha's linguistic observations
Follow up of awarded contracts - DOH expectations met
Where contracted agencies provide services, e.g. rural O#ahu
Substance abuse
HIV prevention case management
Boundary issues/ burnout
Providing TA to community resources so they are more likely to provide HIV prevention

Six PCPG members listed that they or their agency could offer technical assistance in the following areas:
Health care services, transportation, HIV prevention, community planning, setting priorities, writing specific, measurable objectives, overview of current prevention programs, program planning, harm reduction, cultural issues, strategies and interventions, harm reduction, training, use of "epi" data, sex work in Waikiki, domestic violence, women's issues, homelessness, transgender issues, runaway teens.

2000 Technical assistance (TA) plan for community planning

Recommendation 1. Provide technical assistance to the PCPG in the top areas indicated by the survey and from other assessments: overview of current prevention programs, strategies to overcome barriers to prevention, other strategies and interventions, evaluation of HIV prevention programs, cultural issues, assessing community resources, needs assessment of priority populations, and other emerging needs. The Membership Committee and Steering Committee will help create a technical assistance plan to address these needs.

Overview of current prevention programs
Provide an overview of current prevention programs to the PCPG.
Contracted agencies will present an overview of their current prevention programs and provide a written report. In addition, TA sessions will be held to focus either on a particular type of intervention (e.g., PSE outreach or PI) or services to a particular population (TG, MSM, etc.). Contracted agencies will present what's going well, what could be improved, and challenges they face.

Strategies to overcome barriers to prevention
Provide TA to the PCPG on overcoming barriers to prevention.
Community advisory committees will present recommended strategies and interventions to the PCPG. They will be asked to discuss barriers to prevention with their population and to present strategies to overcome these barriers. Contracted agencies' presentations listed above may also address barriers and effective strategies.

Evaluation of HIV prevention programs
Provide technical assistance to the PCPG about evaluation of HIV prevention programs.
SAPB will ask for assistance for the PCPG from The San Francisco HIV/STD Prevention Training Center and the CDC Evaluation Branch.

Cultural issues
Provide TA to the PCPG around cultural issues.
Do further assessment with PCPG members about particular training needs related to culture. Locate speakers who can present information about "colonization" and internalized oppression and how to resolve some of these issues. Possible resources for this TA include the National Coalition Building Institute at University of Hawai#i, a Hawai#i group that has applied for funding with a NMRO, the Wellness Center, or National Minority AIDS Council.

Assessing community resources
Provide TA on assessing community resources.
A presentation about *how to assess* community resources will take place at a PCPG meeting and will include a list of resources. The Needs Assessment Committee will explore the usefulness of updating the *HIV/AIDS Resource Directory for Organizations in Hawai#i* and the community resource inventory and will ask SAPB to update them, if needed. Distribute more widely *A Healing Path* (a manual for HIV positive individuals).

Needs assessment of priority populations
Provide TA on needs assessment of priority populations.
CHOW can present to the PCPG their annual report on needle exchange and injection drug users or distribute the report to PCPG members. Contracted agencies may share their needs assessments results with the PCPG. A presentation about the findings of the women's needs assessment can be scheduled. Ask TGEOP to develop and present a needs assessment of TGS.

Enhancing participation of group
Enhance participation of PCPG group members by providing TA in consensus building, group facilitation, public speaking, conflict resolution, and creating safety to promote discussion.
Ask National Coalition Building Institute or other resource at UH for this TA.

Other strategies and interventions

Provide a TA session for the PCPG that reviews interventions/strategies/models that have been "tested" or are currently being implemented elsewhere with populations that have some similarities to Hawai#i culturally or geographically.
Contact project officer and behavioral science experts at CDC to recommend literature that is relevant to Hawai#i's populations. Contact NMRO (Asian Pacific Islander Health Forum) to recommend relevant literature to API populations.
Another format to explore is for teams of two PCPG members each to present summaries of key articles at a PCPG meeting.

2000 Technical assistance plan for prevention providers -- CBOs and SAPB

SAPB will continue to provide technical assistance and consultation on program development to contracted community-based organizations (CBOs) in order to facilitate timely provision of HIV prevention services to at-risk populations. A plan to address the needs highlighted by the EDs and their staffs (in their responses to a survey distributed to them in mid-1999) is being developed for the year 2000. Results of the survey indicate that the technical assistance needs most requested were related to program planning and evaluation; strategies for meeting the needs of high-risk populations, including training on individual and group level interventions; safety issues for outreach educators; and strategies for overcoming barriers to HIV prevention. The plan for delivery of TA in 2000 meets the needs of SAPB staff, as well as those of CBOs. AIDS Education Project (AEP), which has provided trainings to contracted CBOs throughout 1999, will again be contracted to provide three separate trainings to SAPB staff and to outreach staff of each of the seven CBOs contracted to provide HIV prevention services to at-risk populations. This form of technical assistance will be enhanced in the year 2000, with trainings continuing to be provided on topics which will build upon the subject matter which AEP covered in 1999. The trainings will continue to be based on behavioral intervention theory, harm reduction, HIV counseling and testing outreach strategies, and other strategies related to the delivery of HIV prevention services to at-risk populations. Training topics will address the needs expressed by the outreach workers in the needs assessment and will be addressed through didactic presentations, role-playing, skills building and other techniques which will engage the participants in the learning process. SAPB will collaborate with the California HIV/STD Prevention Training Site to develop a two-day training which will address the implementation of program planning and evaluation in a meaningful and practical manner for CBO executive directors and outreach prevention workers. The CHSPTS has expertise in these program areas and has previously provided prevention trainings in Hawai#i.

SAPB staff will coordinate four AIDS Educators' Quarterly (AEQ) meetings. AEQ meetings enable contracted outreach educators to network and share information regarding providing HIV prevention services to at-risk populations. These meetings also serve as a forum for a "focus session," an in-depth presentation of a topic relevant to their work.

SAPB staff will also support the quarterly meetings of the community advisory committees (CACs) for the seven focus populations (MSM, women at-risk, IDU, youth, the transgendered population,

Hawaiians, Filipinos). These meetings will allow outreach educators to meet with others who are serving a similar population to exchange ideas on strategies and interventions for these populations. These meetings will also serve as a means of ensuring cultural competency and sensitivity to gender and sexual identity in such strategies and interventions. They also will facilitate communication between the outreach educators and the CPG to further the understanding of CPG members regarding effective HIV prevention services for these populations. SAPB staff will also provide two on-site technical assistance visits to each of the CBOs contracted with the SAPB to provide HIV prevention services.

SAPB staff will receive technical assistance in evaluation from a consultant who will be hired to assist the staff to manage evaluation of HIV prevention programs statewide. SAPB staff will request technical assistance as needed from CDC about PCRS and counseling and testing.

2000 Recommendations

1. Explore the prevention case management model to provide linkages to other social services and other agencies as needed in areas where gaps and risk management issues occur. This model may enhance prevention work and make it more client-centered. To develop outreach workers' abilities to make referrals.

Needs assessment

Progress and accomplishments (July 1998 - June 1999)

MSM needs assessment

Val Kanuha, Ph.D., School of Social Work at the University of Hawai#i, was selected to do a needs assessment of high risk MSM. The research question was "How does ethnicity affect risk behavior and access to HIV prevention services?" The Needs Assessment Committee met with Dr. Kanuha several times during the planning and implementation of the study.

Dr. Kanuha, reported to the PCPG at the March 1999 meeting her findings from the 1998 needs assessment project titled *A needs assessment study of Asian and Pacific Island gay and bisexual men and HIV risk in Hawai#i.* She explained that her report presents the findings of an exploratory study of men in Hawai#i who identify as gay or bisexual, and whose primary erotic and sexual contacts are with other men (MSM). From August to November 1998, in-depth interviews were conducted with 24 gay- or bisexual-identified men from the islands of O#ahu, Kaua#i, Maui and Hawai#i. The majority of study participants were of Asian or Pacific Island (API) descent and were lifetime residents of Hawai#i.

Findings from API MSM needs assessment

1) Greater social and cultural value is placed upon family loyalty than upon enactment of individual roles and behaviors. API-MSM in Hawai#i are socialized to honor the social roles and expectations of the family institution, and all participants mentioned their families as their most significant social support.

2) Coherence between one's gay/bisexual and API identities are simultaneously accompanied by tension between needing to protect oneself and one's family of origin from social stigma. The men in this study were very comfortable claiming their sexual identity as gay or bisexual, despite the fact that many of them are not actively affiliated with any organized gay social networks. However, at the same time, respondents reported an ongoing tension in trying to balance pride and comfort in privately being gay while preserving the family by publicly not "acting" gay.

3) Love and intimacy are built upon and idealized by expectations of mutual trust between intimate sexual partners. In this frequently reported theme, API-MSM described the desirability of being in primary (though not necessarily monogamous) intimate relationships. Most men believed that familiarity with one's sex partner assured trustworthiness regarding their partners' HIV status and risk behaviors.

4) Cultural norms particularly among Native Hawaiian and other Pacific Island racial/ethnic groups establish social roles and sexual expressions of giving and pleasuring others. Some Native Hawaiian and Pacific Island respondents suggested that cultural values such as *mälama* and *aloha* sometimes put them at risk because pleasing their sex partners can be more important than maintaining HIV risk reduction beliefs and practices.

5) Safer sexual practices are intentionally and situationally abandoned based upon conscious deliberations about risk. This finding suggests that behaviors which reduce HIV transmission are interrupted due to a conscious and deliberate cost-benefit analysis about sexual encounters and sex partners. This decision-making process is significantly influenced by cultural and contextual factors.

6) Fatalistic beliefs about contracting HIV are associated with male and gay identity. Fatalistic attitudes and beliefs about becoming HIV infected are based on the dual social constructs of "male" and "gay male" identity, and the requisite behaviors associated with being both a man and being gay.

Dr. Kanuha's recommendations are in the 2000 recommendations needs assessment section of this plan. For a copy of the report of this needs assessment, contact Dr. Val Kanuha at the School of Social Work, UH at Manoa 956-6239, or Katalina McGlone, STD/AIDS Prevention Branch, DOH,

733-9010.

MSM/IDU needs assessment

The Needs Assessment Committee (NAC) in 1998 recommended that any program designated to serve MSM/IDU must conduct a needs assessment of MSM/IDU, plan a specific program to effectively serve MSM/IDU, and include information on MSM/IDU in their evaluation. This requirement was listed in the request for proposals (RFPs) for the state-funded needle exchange program. The Community Health Outreach Work Project (CHOW) has designed a needs assessment for this population which is slated to begin July 1999. Don DeJarlais (a leading researcher in needle exchange programs) wrote the study plan. The first part will be a literature review. The second part will seek information from the 24 U.S. syringe exchange programs that report having special outreach programs to MSM/IDU. The third part will be an ethnographic study of MSM/IDUs in Hawai#i. The sample will include 25 MSM/IDU who use the syringe exchange program and 25 who do not use it, although they may be difficult to find. He expects that this part of the study will take six months. The study will include life history interviews and questions to identify the specific contexts in which the MSM/IDUs are at high risk for becoming infected with HIV or for transmitting it to others. Current needs for services and obstacles to obtaining those services will be part of the interviews. The interviews will seek to discover "life goals" of MSM/IDUs that may serve as a basis for positive behavior changes. CHOW acknowledged that MSM/IDU are not a single homogenous group. Based on the findings, CHOW will develop a plan for special services for MSM/IDU.

In addition, the CHOW Project will provide its annual needle exchange program report or present their findings to the PCPG. The report contains information about injection drug users that would be useful for better understanding this priority population and for planning.

Data collection

The Needs Assessment Committee and the Evaluation Committee held joint meetings (November 1998 and January 1999) to provide guidance for and to receive a report of the data collection project. Together they discussed the information to collect, the feasibility of collecting it, and the uses of the data.

The data collection forms include the ethnicities that contracts address which are also of interest to community planning. The data collection system covers a lot of the needed process evaluation. The data collection forms are designed in a way that other data variables could be added to the form, when needed. The consultants designed a data management system using Excel and drafted report formats. Excel was chosen for the current time because of its availability to contracted agencies. The consultant recommended that SAPB give reports about the data to program staff who collect the data as well as to community planning. The data collection system works best when there is an information loop. It was proposed that there be quarterly discussion of data collection in all CACs and GayMAP meetings, to insure that everyone is using the same definitions, to hear about progress with using the forms, and to learn from the data.

The forms need to be reviewed, possibly modified, and piloted for prevention work aimed at other priority populations. It was proposed to bring together education and program staff and the ASO directors for a training on the use of the data collection instruments.

Other
At the May 3, 1999 meeting, the NAC recommended that a presentation about the HIV prevention needs of the mentally ill be held at a PCPG meeting. The NAC identified possible presenters. This presentation took place at the July 1999 meeting of the CPG.

2000 recommendations for needs assessment

The Needs Assessment Committee brainstormed other needs assessment projects that were considered for the year 2000. However, since the women's needs assessment did not take place in 1999, it became the priority for 2000. The following proposed topics or populations might be considered if there were more funds available for needs assessment: HIV + people or men, African Americans, OCCC/ HIV+ individuals in prison, young MSM, design of interventions using telephone prevention counseling and Internet for youth MSM and MSM of color, and PSEs (public sex environments).

1. The focus of the needs assessment project for the year 2000 will be women at risk for HIV.

The NAC decided to proceed next year with the project that had been approved for 1999, but which got cut. In May, the legislature released a two-year retroactive pay raise, which was not budgeted, yet had to be paid from this year's budget. Since the contract for needs assessment had not been finalized, these funds were used to cover the mandated retroactive payroll increase.

Since the paperwork for the women at risk needs assessment was close to completion before it was tabled, SAPB will submit the paperwork in early fall for an early January 2000 start date. The needs assessment will focus on women at risk for HIV and women who are HIV positive. HIV prevention workers, case managers, researchers and others who work with women at risk for HIV and HIV positive women will be consulted for their insights. The final report will include findings from a literature review and other successful programs, a description of needs, unmet needs, barriers to access and recommendations on effective strategies to access women at risk, components of effective prevention programs to serve women at risk for HIV, and information that will deepen our understanding of this population, such as their motivations, perceptions of risk, strengths, possible contributing factors to their risk behaviors, life context, views toward prevention programs, safe sex, and access to treatment for HIV.

2. Dr. Val Kanuha's needs assessment findings will be considered in the development of strategies and interventions for MSM.

Study recommendations from Dr. Kanuha

3. **Increase recruitment, training and visibility of positive role models who are API, "local" (born and raised in the islands), gay men, and who are able to manage being "gay-identified" while maintaining their ties to their local roots.**

The lack of positive role models for all age cohorts was indicated as an important need by many respondents. Based on the analytical framework presented, these role models must be individuals who are able to demonstrate successful incorporation of "locally" relevant, racial/ethnic social roles, management of oftentimes conflicting social identities, and responsible and healthy behaviors. These persons should be utilized in various organizational positions including program planning, outreach, HIV/AIDS prevention education, development and fundraising, and research and evaluation.

4. **Employ more ecological, holistic, and integrated approaches that demonstrate the ways API and other men of color can learn to manage competing social roles, identity development and behavior regarding sexuality, race/ethnicity, and gender in a uniquely "local" Hawai#i context.**

One example of this approach might include 1) intrapersonal or individual level strategies that focus on the inherent conflictual but resolvable aspects of an API-MSM identity and the effect of same on positive health beliefs and practices, 2) interpersonal strategies that offer positive messages for gay/bisexual identity and HIV risk reduction among API-MSM, families, employers, and others in their social network, and 3) community-level interventions directed at lesbian, gay, bisexual, transgender (LGBT), HIV/AIDS, API and other health and social service professionals, as well as other more general audiences (churches, community groups, Native Hawaiian social groups, schools).

The main objective of this ecological approach is to portray positive images of API-MSM that also preserve the integrity and traditions of racial/ethnic families in Hawai#i . Examples of this community-level approach are a Hawai#i version of the video, "Coming Out, Coming Home," an educational video of API gay men, lesbians and their families (Asian and Pacific Islander Parents and Friends of Lesbians and Gays, 1996) or the Asian and Pacific Islander Homophobia Education Campaign in Washington that produced the "Unite Against Homophobia" poster.

5. **Use of culturally-based messages that are specific to Hawai#i's racial/ethnic, class, historical and "local" community should be developed and broadly utilized.**

Hawai#i's emphasis on relationships and maintaining harmonious public/social connections is both a barrier and asset for successful HIV prevention education for those MSM most at risk. However, utilizing this cultural norm to disseminate messages of care and self-care in the context of maintaining values and traditions of *#ohana*, *m~lama*, and *lÇkahi* may have inherent appeal to Native Hawaiians and other racial/ethnic groups, gay and non-gay alike. In addition, engaging influential public figures who are willing to support HIV prevention messages that incorporate public understanding for API-MSM identity might be another culturally appropriate and effective mechanism.

6. **Use of both single-identity and mixed groups for HIV/AIDS prevention and social support should be pilot-tested. API-MSM facilitators who are also familiar with Hawai#i 's local racial/ethnic, class, and sexual politics are recommended for both types of groups.**

The use of group-level HIV/AIDS interventions has been recommended as more cost-effective than individual-level strategies. Consistent with the preceding recommendations, interventions should incorporate information about and management of social roles, public/private identities, and behaviors focused on race/ethnicity, LGBT identity, gender, class, and other culturally relevant "selves" as they impact HIV risk. API-MSM need programs that are not focused solely or even primarily upon HIV risk reduction, but upon the social supports necessary to ensure more consistent risk reduction behaviors.

In addition, group-level interventions might integrate the use of more naturalistic settings to mediate the stigma associated with an ASO or other HIV/AIDS-related program, such as linking group activities and HIV prevention programs with gay and local-friendly churches or cultural settings and practices (hula competition/exhibitions, fashion shows, theatre, art and dance performances).

7. **Participants perceive that there is inadequate outreach at public sex environments (PSEs). Use of the diffusion model with natural leaders who are bisexual and not gay-identified to do outreach and other kinds of HIV prevention is one possible strategy.**

The stigma attached to bisexuality is socially much stronger than homosexuality. However, in the local context of Hawai#i, it is not as uncommon nor as unusual as in other cultural settings. HIV/AIDS service agencies must create a sensitive and culturally competent environment in which the complex political and social issues associated with bisexuality among men at risk in Hawai#i can be discussed. An important next step would be to recruit bisexual men - again, also locally-identified and API - who are willing and able to be trained to gather ethnographic information especially with regard to the actual behavioral risks commonly associated with this target group. Future HIV prevention programming cannot be designed without more information about bisexual men and HIV risk.

8. **To negotiate the barriers of both social stigma and geographic distance for many local gay men especially outside the Honolulu area, social support programs that do not require publicly attending HIV/AIDS or "out" gay programs might be designed.**
A number of participants reported discomfort about attending HIV/AIDS prevention programs at agencies that were either "publicly" gay- or HIV-identified. In addition, the need to balance social support for one's gay or bisexual identity with racial/ethnic identity especially as they impact engaging in HIV risk behaviors calls for a multifaceted program analysis and design to reach this population.

Use of a peer phone counseling model has shown impressive results in reducing HIV risk behavior among men in Washington (Roffman, Picciano, & Kalichman, 1997). The success of this program is due in part to the anonymity that participants may maintain. Program models that utilize telephone or electronic technology (e-mail, chat rooms, etc.) might be piloted as one means to enhance social support for those gay and bisexual men in Hawai#i who do not have socialization venues or

opportunities to reinforce positive images of sexual identity and self-efficacy regarding HIV risk reduction behaviors.

9. **Development of cooperative funding proposals to enhance collaboration across HIV/AIDS, racial/ethnic, LGBT, arts, and other culturally significant organizations might be explored.**

The preceding recommendations might benefit from collaborative efforts that integrate rather than segregate services and programs targeted to API-MSM. Innovative program proposals that demonstrate application of some of the study findings should be funded.

10. **All HIV/AIDS prevention efforts recommended in this report must be undertaken with a research and evaluation component to measure significant behavioral and other outcomes linked to reducing HIV transmission among MSM populations in Hawai#i.**

Clearly the CPG has made a commitment to ongoing research and evaluation. These efforts must continue, including diversifying the acquisition of local funding sources to expand some of the best practices already begun.

Evaluation

Progress and accomplishments (July 1998 - June 1999)

The Evaluation Committee and the PCPG recommended evaluation assistance be available to contracted agencies for 1998. Organizations had the opportunity to apply for this assistance and the two that applied, Life Foundation and Ke Ola Mamo, received assistance. Chuck Mueller, Ph.D. from the Social Welfare Research Unit of the University of Hawai#i received the contract to provide this evaluation consultation.

Dr. Chuck Mueller and Orlando Garcia conducted a process **evaluation of the counseling and testing outreach program** through Life Foundation. The evaluators compared demographic and other characteristics of clients from the OraSure outreach counseling and testing program to high risk MSM on O#ahu with MSM clients of Diamond Head Health Center. The information was obtained through examination of the HIV test forms completed by the counselor-testers for each test. Characteristics included information about condom use, number of sex partners, history of other STDs, and alcohol use. There were differences between the group reached by Life Foundation (LF) and the MSM tested at Diamond Head Health Center. The report included a description of the program, a discussion of issues related to counselor-client boundaries, personal safety and liability, staff support and training, confidentiality, the effect of counseling and testing on outreach, and the need to strengthen follow-up and referral systems. The evaluation consultancy provided program and evaluation recommendations that could be used statewide for the outreach counseling and testing program.

The three evaluation recommendations follow.

1. Community-based organizations (CBOs) and AIDS service organizations (ASOs) that implement sufficient outreach counseling and testing should consider evaluating these services. Were this to be pursued, CBOs and ASOs are encouraged to develop specific goals and objectives (e.g., increase proportion of tests being conducted with a particular population, increase post-test follow-up rates, increase number of test-takers who follow-up with referral services) and then implement relatively simple agency-based evaluation procedures. These procedures could include collaborating with the DOH to extract useful data from the Statewide HIV Antibody Test Form data base and conducting process evaluation including staff and client interviews.

2. Consider a statewide evaluation of counseling and testing services (clinic and outreach based). Potential directions for such an evaluation might include using the HIV Antibody Test Record Form to examine demographic and risk behavior profiles, HIV-status and follow-up post-test counseling rates across testing sites, with a focus on identifying strengths and weaknesses in the statewide system and ways that the system can be improved (e.g., developing new sites, using other testing technology, etc). Consider including client perspectives in any such evaluation.

3. The DOH, in collaboration with community input, is encouraged to continue its review and modification of the existing HIV Antibody Test Form and the associated data management system. This evaluation pointed to the need to carefully develop standardized measures of risk behavior and to develop ways to identify transgendered individuals, along with other more subtle changes (e.g., developing new categories for length of residence, updating terminology for ethnic identity). In addition, it might be useful to add a category that describes the type of outreach site where the test was conducted (e.g., PSE, fixed-site, client's home, CBO/ASO office, etc). Finally, it might be useful to add an item related to how the client heard about the counseling and testing program. In general, a review of the proposed modifications would be strengthened by considering what statewide evaluation questions and answers are anticipated to be useful in future years and assuring the data are collected in a way that will provide answers to these questions.

Dr. Mueller arranged for Alice Tse, Ph.D. to serve as an evaluation consultant to Ke Ola Mamo. Dr. Tse reviewed a survey that was developed by Ke Ola Mamo to gather information about transgendered individuals (TGS) for their prevention intensive intervention model. Dr. Tse gave suggestions to revise the survey and program recommendations. Ke Ola Mamo's rationale for this outreach project for TGS and their survey and its results provide needs assessment information and some program development guidance to other organizations statewide that want to serve TGS.

Dr. Mueller presented both of these reports at the March 1999 PCPG meeting. Copies of these reports are available from the SAPB.

Upon the recommendation of the Evaluation Committee, the requests for proposals (RFP) for HIV

prevention projects funded by federal and state monies that were to begin in 1999 have asked organizations to justify their program design based on behavioral and social science theories, the literature, evaluation and experience in other locations, and/or needs assessments. In addition, the RFPs have asked organizations to submit a plan for evaluating their programs with their proposals.

With the assistance of a consultant from SMS, SAPB created the first phase of a standardized data collection system in late 1998 and continue to pilot test it in 1999. This data collection system will collect data from all health education and risk reduction (HERR) programs regarding what services are being provided and who is receiving these services. The first phase included design of data collection instruments/forms, a system, and report formats. The instruments will enable us to answer process evaluation-related questions. In the past, it has been frustrating trying to write the annual progress report to CDC, because all agencies do not provide the same type and amount of data. The forms were developed and pilot tested for MSM programs. The implementation of the data collection system has begun with two of the five CBOs contracted to provide services to MSM using the data collection tools. This limited implementation revealed the need for further revision of the system. Also, these forms need to be reviewed, possibly modified, and piloted for prevention work aimed at other priority populations. There is a lot of work that can be done to implement the new system of data collection. Because it will be the first year, it is hard to anticipate all the problems or needs that will come up. It was agreed by the Evaluation Committee and the PCPG that the SAPB will need some resources to support the data collection process. Tim McCormick from SAPB is coordinating these efforts and Chuck Mueller is the evaluation consultant for 1999 who is available to provide evaluation consultation on data collection and other evaluation issues to the SAPB.

The following recommendations for the 1999 prevention plan were approved by consensus by the PCPG in the first half of 1998. In *italics* is an indication of progress made on each recommendation.

1. Assist the STD/AIDS Prevention Branch (SAPB) in establishing a data collection system for all HIV prevention activities and programs conducted by SAPB and contracted agencies. The standardized data collection of HIV prevention activities will answer the basic questions about who is receiving prevention services (e.g., number of individuals, gender, ethnicity, sexual orientation).
   Partially complete. It has been designed and is being tested in various locations.

2. Review and evaluate the Counseling and Testing program and make recommendations and a plan for the future. PCPG members will have input and participation in this process. A report of the counseling and testing plan and recommendations will be due by July 1, 1999. Input from this report may be used to affect the year 2000 CDC grant application.
   Complete. Changes in the counseling and testing program are currently being implemented.

3. In subsequent years, other SAPB programs (such as, HERR or partner notification) may be the focus of a systematic evaluation.
   Partner counseling and referral services (PCRS) is a possible focus for the year 2000.

4. Support evaluation services to contracted agencies in 1999. The consultant hired could work with agencies which are at differing levels of evaluation readiness, offering them assistance appropriate for their level of evaluation knowledge and practice.
This service was not developed by the Evaluation Committee and was subsequently cut. Services being provided in 1999 include continued development of data collection system and evaluation technical assistance to SAPB staff.

5. In 1999, reexamine effects of the evaluation expenditures. Has it been effective to provide evaluation technical assistance? This review will be available by May 1999, in order to influence the year 2000 CDC grant application.
Complete. The Evaluation Committee unanimously agreed to continue with evaluation and discussed various reasons for their support. Their reasons follow:
   - *We may need more support for data collection and capacity building in year 2000 or beyond.*
   - *If we are required to provide outcome monitoring of HE/RR individual and group interventions in 2001, we may need help to prepare in 2000, so we will be ready. The consultant could provide information about the advantages and disadvantages of having this type of evaluation standardized across the state or individualized by agency.*
   - *It is important for organizations that receive funds to evaluate and be accountable for the use of these monies and to learn their strengths and where they need assistance to improve their program.*
   - *We are spending a lot of money on programs for populations; we need evaluation to get the most benefit from these funds.*
   - *Evaluation can improve program effectiveness.*
   - *Research and evaluation can empower the workers. They should know if what they are doing is making a difference. How can the impact be measured? What kinds of things are difficult to measure?*
   - *Many people working in HIV prevention may still need a basic orientation about evaluation*
   - *CDC is likely to put increasing attention on evaluation*
   - *By doing evaluation now, we can establish baselines before we start new programs based on needs assessment findings.*
   - *From our evaluation efforts, other organizations can replicate what is working well about our programs.*

6. Technical assistance consultation in evaluation will be made available to SAPB staff to raise the level of sophistication of program evaluation.
In process. A consultant from University of Hawai#i, Chuck Mueller, Ph.D. will be providing this assistance. This consultant is well versed in prevention issues and is a former CPG member.

7. Planning, decisions and paperwork for the 1999 evaluation services will be done within the next

couple of months, so that services can begin on January 1, 1999 and inform programs' implementation as early as possible.
The Evaluation Committee postponed decision making about the specific focus of 1999 evaluation project until after the reports from the 1998 evaluation, needs assessment, and data collection projects could be reviewed. The evaluation consultant is to begin in August 1999.

8. Provide statewide minimum standards for the evaluation activity of data collection in all contracts.
This work is in development via the contact data collection and recording form. Data collection forms were piloted for MSM and site tested and are currently being revised. At the point that the form is complete, PCPG members will review it.

9. Evaluation efforts will be focused on facilitating and developing high *quality* HIV-prevention. In this context, high quality is informed by a combination of behavioral science findings and local knowledge.
This long term goal is in process.

10. Evaluation findings (both internal and external to DOH) will be shared with the PCPG on a regular basis. This evaluation information can be used to help identify priority populations and plan for effective services and interventions. Exceptions to this can be made, contingent on agreement between DOH and PCPG.
Reports from the 1998 evaluation projects were shared with the PCPG via written copies and oral reports. Oral reports have also been given at meetings of the Evaluation Committee of the PCPG, of the statewide Health Educators' Quarterly, and at appropriate advisory committees such as GayMAP. The committee would like to eliminate the last sentence of the prior year's recommendation as they feel it is not necessary.

In addition, these long-term recommendations were approved by the Evaluation Committee and the PCPG in 1998:

11. That the HIV prevention community in Hawai#i continue to move toward developing and implementing high quality prevention services.

12. That evaluation becomes a part of the "normal" strategies used by HIV prevention organizations (state and non-profit) to enhance and to help assure quality delivery of HIV prevention services.

13. That the HIV prevention community in Hawai#i works toward contributing knowledge to other states about HIV prevention, by including some "cutting edge" programs and evaluation activities. While not limited to this, one potential emphasis might focus on prevention as it

relates to the unique cultural and ethnic factors present in Hawai#i.

2000 recommendations for evaluation

The Evaluation Committee and the PCPG approved the following recommendations for the year 2000:

1. Continue data collection implementation statewide and review of this new system.

2. Determine if other evaluation methods are needed.

3. Develop outcome monitoring system for HE/RR individual and group interventions in the year 2001. The development would include deciding on an approach (standardized or individualized by agency or some of both), actual instruments, training, and other guidance.

4. Provide to grantees (contracted prevention workers and executive directors) technical assistance, such as an evaluation orientation and update.

5. Include evaluation as a requirement of programs in the request for proposals (RFPs).

Development of a comprehensive evaluation plan

Hawai#i is to develop a comprehensive evaluation plan for the years 2001 - 2003. This plan is to be submitted to CDC with next year's grant application (in September 2000).

Timeline

A proposed timeline to develop this plan follows:

October 1999:

The evaluation consultant will help to assess health department evaluation resources and capacity and evaluation needs and priorities.

November 1999:

Upon receipt of the CDC evaluation guidance document, it will be sent to the Evaluation Committee, the evaluation consultant, and SAPB staff who may be involved in the development of the evaluation plan.

The SAPB staff will meet with the PCPG Evaluation Committee to discuss the evaluation guidance and recommendations for Hawai#i's three year evaluation plan. SAPB staff will draft recommendations for process evaluation of major activities and programs and outcome monitoring of individual and group level interventions. The SAPB staff will include these recommendations in a proposed comprehensive evaluation plan.

January 2000:

The SAPB staff will meet with the Evaluation Committee and discuss the draft recommendations and obtain feedback and other ideas and strategies. Modifications will be made as needed.

February 2000:

A mechanism will be set to obtain feedback and input from administrators and prevention workers from contracted agencies through meetings, conference calls, written surveys on the draft evaluation plan.

Distribute draft to PCPG members and solicit their feedback.

March 2000:

The revised evaluation plan will be reviewed by the Evaluation Committee, SAPB staff, and other interested stakeholders including community advisory committees.

April 2000:

SAPB staff will present the final revised plan to the Evaluation Committee and the PCPG for their review and approval.

May 2000:

The SAPB will make decisions about implementation of the plan recommendations.

Who will be involved

DOH STD/AIDS Prevention Branch

HE/RR staff, the counseling and testing quality assurance and training coordinator, the community planning coordinator, and the branch chief.

The PCPG

Evaluation Committee of the PCPG

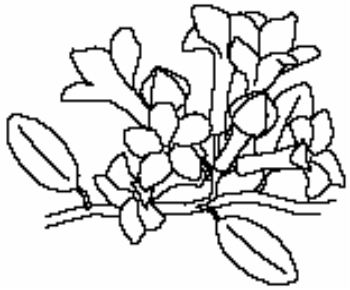
All PCPG members

Other stakeholders

Administrators and prevention workers from contracted agencies.

Roles and decision making

The SAPB staff with input from the Evaluation Committee will prepare a proposed plan for evaluation. The PCPG and administrators and prevention workers from contracted agencies will be asked for their feedback. The PCPG will vote on the final plan.



Epidemiologic profile

1998 epidemiologic ("epi") profile

The PCPG requested a 1998 epidemiologic ("epi") profile update report. Because of a change in the reporting requirements, since January 1998, labs must report low CD4 count test results to the Hawai#i Department of Health AIDS Surveillance Program, which gives surveillance staff information to track new cases. Perhaps because of the reporting requirement change, more cases were reported in 1998 than in recent previous years. The PCPG wanted to have the latest data in preparation for planning, and in particular for the priority setting process which will take place in early 2000. Dr. Sara Millman from Hilo presented the epidemiologic profile report to the PCPG at the June 1999 meeting. The profile describes the limitations of each type of data used. The profile includes 1998 data about AIDS, HSPAMM, counseling and testing program, STDs, and ASO clients.

Because the Prioritization Task Force of the CPG will begin prioritization of populations for prevention services in January 2000, 1999 data may not be available in time. For this reason, the community planning group requests additional information using 1998 data.

2000 recommendations for epidemiologic profile

1. The CPG recommends that additional epidemiologic information be available in January for use in prioritization. Having visual representations of case numbers provides a clearer picture of the situation and promotes understanding. The information requested by the CPG includes **graphs** of case numbers which include 1998 data combined with several previous years of data.

AIDS Surveillance data of

various racial/ethnic groups by risk behavior (Caucasians, API, Hawaiians, Filipinos, Hispanics, African Americans, Japanese)

e.g. AIDS cases of Hawaiians by risk behavior

risk factors by ethnicity

e.g. MSM AIDS cases by race/ethnicity

gender by risk behavior

e.g. Showing numbers of females by risk behavior

gender by ethnicity

e.g. Showing numbers of females by ethnicity

AIDS cases of Hawaiians by age group

HSPAMM HIV data

gender by ethnicity by age of HSPAMM HIV cases

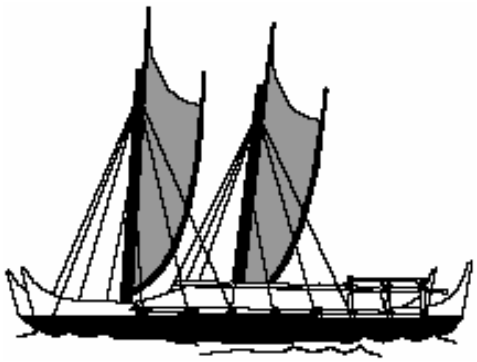
e.g. 20- 29 year old HIV+ females in HSPAMM by ethnicity
e.g. 30-39 year old HIV+ females in HSPAMM by ethnicity
e.g. 20 - 29 year old HIV+ males in HSPAMM by ethnicity
e.g. 30-39 year old HIV+ males in HSPAMM by ethnicity

Counseling and testing data

Also to be included in the "epi" profile update is HIV counseling and testing data for the first six months of 1999.

2. The HIV/AIDS Surveillance program will include HIV report data in the "epi" profile as it becomes available. The HIV/AIDS Surveillance Program in SAPB is planning to commence unnamed HIV reporting in Hawai#i in early 2000. Reporting will provide increased and more relevant data for prevention planning. Demographic and risk behavior data similar to AIDS reporting will be collected. As this information is available, it will be distributed to the PCPG.

3. DOH AIDS Surveillance staff will prepare the *AIDS Surveillance Quarterly Report* four times in 2000 and it will be available to the PCPG and posted on the DOH website.



Counseling and testing

Much work occurred in this area over the last year. This section first reports on progress on the recommendations made by the PCPG in 1997 for 1998. The remaining pages are elements of the process and recommendations of the strategic plan released in May 1999. (See table of contents.)

Progress and accomplishments (July 1998 - June 1999)

These recommendations were approved in 1998 by the PCPG for 1999. The progress on the objectives is written in italics.

1. Prepare a strategic plan for the counseling and testing program for the year 2000. The program will be reviewed, evaluated, and reconfigured or re-engineered to more effectively reach at-risk populations. PCPG members will have input and participation in this process. Peter Whiticar, SAPB Branch Chief, has been invited to work with the Counseling and Testing Committee in developing the strategic plan. A report of the counseling and testing plan and recommendations will be due by May 1, 1999. Input from this report will be used to write the year 2000 CDC grant application.
   Complete.

2. Explore providing test results by phone.
   Providing test results by phone is included in the recommendations for 2000 - 2001.

3. Provide intensive training based on stages of change and harm reduction to DOH counselors and outreach workers so they can provide intensive prevention counseling, which would be performed over multiple sessions with high risk negative individuals volunteering for services.
   All counselor and testers from DOH attended a harm reduction workshop in August 1998. An HIV counselor training needs survey distributed in late 1998 indicated that the majority of counselors were interested in advanced counseling skills. The AIDS Education Project is providing intensive prevention counseling training to outreach workers. Two trainings in 1999 were on behavior change theory and individual counseling.

4. Because it has been shown that offering anonymous testing increases use of services over confidential testing, we should give serious consideration to the manner in which HIV reporting is done in anonymous sites and support the continuation of anonymous testing.
   Will continue to be considered as HIV reporting using a proposed unnamed test code is further developed. Anonymous test sites will continue. HIV reporting will be voluntary by a unnamed test code.

5. Review Hawai#i's counseling and testing form, and consider making changes to the Hawai#i data collection form to collect more "epi" data. (Hawai#i's form collects more information than

CDC requires.) Information is entered into the computer and sent to CDC. The form can be submitted to the PCPG in May along with the recommendations.
Input has been collected from the Counseling and Testing Committee and SAPB staff. In addition, the consultant who evaluated the outreach counseling and testing program also made recommendations regarding the form. The revision of the form is almost finalized.

6. Screen clients of CTR (counseling and testing, referral) and offer graduated levels of counseling based on risk behavior. Those with high risk behavior or from populations with high seroincidence would be given more extensive counseling and referrals, possibly through providers who offer other prevention interventions. Those with low risk behaviors or from populations with low seroincidence would be tested with only informed consent and minimal pre-test counseling. Low risk individuals who inquire by phone about counseling and testing would be encouraged to see private physicians or health clinics.
Most of this recommendation is included in the strategic plan for 2000 - 2001.

7. Increase coordination with community organizations to establish and/or broaden collaborative efforts to reach high risk rural populations (e.g., MSM, IDUs, youth, women, minority ethnicities, etc.).
Training for outreach prevention workers in counseling and testing, including the use of OraSure, was provided in 1998. Workers from five agencies contracted to provide HIV prevention to high risk populations attended. This training was also offered to the other two contracted agencies, but they were unable to send outreach workers to the training. Another training is being offered this year.

8. Provide CTR to individuals being released from prison; collaborate with probation and parole to establish a continuation of services, if needed.
This was to be presented to the Corrections, Probation, Parole Community Advisory Committee, but this advisory group was discontinued after HIV prevention funding for this population was redirected to other at-risk groups.

9. HIV counseling and testing should be provided either directly and/or in collaboration with another agency or DOH in all contracted HIV prevention interventions (including group level interventions with groups at risk).
This recommendation has been included in the contracts. Counseling and testing is provided either by the contracted ASO or through DOH counseling and testing sites. Outreach workers have been trained in most locations. In other cases, DOH counselor-testers are available to ensure access to counseling and testing.

10. Target at-risk populations in outlying / rural communities with counseling and testing messages through increased local media information dissemination routes, (e.g., community publications, word of mouth, rehab center activities, N.A., A.A., mature adult activity centers, bathroom areas on beach, 7-11s, check cashing sites).
ASOs that have prevention contracts are to use some of their public information funds to

publicize all counseling and testing options to high risk groups. Counseling and testing is also publicized to injection drug users through CHOW staff and their peer program on the Big Island.

11. Innovative service delivery and outreach practices, including new technologies for testing, such as OraSure and rapid testing, to reach the highest risk individuals should be explored and expanded. These would include strong quality assurance and training components.
Outreach counseling and testing with OraSure has been expanded in the last year. This recommendation is also included for 2000-2001.

12. Offer HIV counseling and testing (including OraSure as appropriate) and referral to the homeless, and mentally and emotionally challenged, on a voluntary basis with their informed consent, using nurses or other staff who already work in agencies that serve these populations.
Outreach workers from Waikiki Health Center Care-a-Van for homeless were trained in outreach counseling and testing. Homeless injection drug users may be served through CHOW and DOH counselor-testers may reach homeless on the Big Island. Additional data are needed regarding needs and available services for these populations.

13. Review utilization data by site to determine level of use and whether high risk individuals are being reached, to identify possible barriers and explore other options to reach these populations.
These data were compiled and reviewed by the Counseling and Testing Community Advisory Group.

14. Counseling, testing, and referral will be provided under the standards and guidelines of the CDC.
The counseling and testing program follows these standards and guidelines.

Evaluation of outreach counseling and testing

See the "evaluation" section for more information about the evaluation that was conducted of the Life Foundation outreach counseling and testing program.

Community advisory group

The Counseling and Testing Community Advisory Group (CAG) met from October 1998 through May 1999. Peter Whiticar, branch chief of the STD/AIDS Prevention Branch, formed this group to advise him in the development of a strategic plan for counseling and testing. The group identified themes and components for a vision of a counseling and testing system for Hawai#i, objectives for the system, characteristics of a system that would promote meeting the objectives, and core issues. The group's final products included a vision, a discussion of resolution of core issues, recommendations in the form of goals and rationale for these goals, and a timeline. This information was presented to the

Hawai#i HIV Prevention Community Planning Group (PCPG) at the May meeting. PCPG members had the opportunity to provide feedback about this counseling and testing plan. At the June 18, 1999 meeting, the PCPG voted to accept the Counseling and Testing CAG's work and recommendations and to include them in this prevention plan update.

Counseling and testing plan for the years 2000 - 2001

Core issues

The Counseling and Testing Community Advisory Group identified five core issues that required resolution before recommendations could be developed. These five issues were discussed at length prior to arriving to a consensus. Summarized below are the issues and related discussion.

1. Who is the focus of HIV counseling and testing? The general population? Those at high risk? Both?

The Counseling and Testing Community Advisory Group decided that individuals at high-risk should be the focus of the state's counseling and testing efforts. Counseling and testing program objectives for each year should clearly set standards of performance, to measure success in serving those at "high-risk."

The committee grappled with numerous issues to identify and define what we mean by "high-risk." In response to this question, the following definitions are presented:

a. **Men who have (had) sex with other men**, particularly those reporting

- unprotected anal sex with other men
- multiple sexual partners within the last six months
- history of symptoms, diagnosis or treatment for gonorrhea and/or syphilis,
- use of IV drugs
- high levels of alcohol and/or other drug use

b. **People reporting a history that includes use of IV drugs**, particularly those who

- are **men who also report sex with other men**
- **share needles with other users**
- have **sexual relationships with other users of IV drugs**

c. **Transgendered** people

d. People reporting a history of **work in the sex industry or "survival sex"**

e. People reporting a history that includes violent and/or **"sexually assaultive" intimate relationships.**

f. People reporting a **history of known transmission exposure to an HIV positive individual** through

- **(unprotected)** anal, oral or vaginal sex
- the **sharing of needles** when using injected drugs

g. People **referred as a result of partner counseling and referral services** (PCRS) provided to a person who has tested positive for HIV.

h. People of color and ethnic groups under-represented in counseling and testing profiles or who historically have had less access to the health care system and who have a history of any of the above mentioned risks.

2. Should counseling and testing services be primarily client-centered (increasing client options) or follow a more standardized protocol to ensure that all clients receive the same services?

The C/T Community Advisory Group agreed that the services should be client-centered. Client-centered counseling and testing allows the consumers choices to best meet their needs. It increases the potential for services to be more effective and efficient. "Client-centered counseling" is defined below, according to the CDC:

"It is tailored to the behaviors, circumstances, and special needs of the person being served. Client-centered counseling is conducted in an interactive manner, responsive to the individual client needs. The focus is on developing realistic prevention goals and strategies rather than simply providing information. HIV prevention counseling should be culturally competent, sensitive to issues of sexual identity, developmentally appropriate, and linguistically specific."

In addition, client-centered counseling and testing services include the main themes for Hawai#i's counseling and testing vision:

- accessible
- use of peers as possible and appropriate
- culturally and linguistically appropriate
- provision of various counseling and testing options to increase consumer
- choice and service accessibility
- testing available at various settings and geographic locations
- skilled, competent counselors
- anonymous and confidential services offered

- linkages to other types of services, as needed (medical, mental health, prevention, social services, etc.)

3. Should counseling be considered separate from testing?

Yes, if people are offered and decline counseling or are provided with limited counseling, they will still be tested and have the opportunity to know their results. (Prior to testing there must always be sufficient counseling to enable clients to provide informed consent.) The issue concerning what constitutes the minimum counseling required to allow an individual to provide "informed consent," needs further development. We reject the notion that counseling is used solely as a one-on-one prevention education intervention for all individuals, in the same way. In a client-centered approach, the provider must be sensitive to the needs and understanding level of the client and when appropriate, must offer/provide additional counseling in a way that is acceptable to the client. The C/T CAG endorses allowing clients maximum choice, which could mean providing only the minimum counseling for some.

These issues are important for consideration, as the SAPB develops administrative rules regarding informed consent for HIV testing. These rules will define the extent of counseling required to be given by all providers. In general, physicians should provide the minimum counseling prescribed by law and by establishing administrative rules that require a low threshold minimum for counseling, that is likely what will be provided.

4. Should we move to a system of offering to provide preliminary results?

"Preliminary results" refers to giving the results after an ELISA test alone, independent of confirmatory testing. Clearly, if the ELISA is negative, then this is the final result. However, when the initial ELISA(s) is either positive or indeterminate, a western blot test is still required for final confirmation of sero-status.

Yes, people should have the option to receive preliminary results. This option and its implications would be explained in pre-test counseling for all clients. By offering this option, we enable clients to have faster access to results. For those with positive or indeterminate results, it may be more likely that they will return for their confirmed results. There are many issues to consider when communicating preliminary results, to ensure that information is provided with clarity and to enhance client understanding.

5. Can positive (confirmed or not) results be given over the phone?

Yes, the CT/CAG agrees that positive results can be given over the phone, if the client chooses. However, counselors should have the option, based on a client-centered approach, to recommend against this option in specific situations. Counselors with concerns will need to work this out with the individual.*

In pre-test counseling, counselors could ask people if they would like to get their results over the phone and explore how the person would feel about hearing information in this way. Specifically asking consumers how they would feel about getting positive results over the phone and offering the option, requires a mechanism to ensure we are giving the results to the right person.

*****Counselor prudence is required in the client-centered approach. If it appears that a client could be in danger were results given over the phone, the counselor would explore this concern with the client and encourage receiving results in person. Whether positive results are given over the phone or in person, there is a need to ensure linkage with appropriate medical and support services.

Summary of Vision, Goals and Recommendations for Counseling and Testing

Vision for Hawai#i's counseling and testing system

To provide **high-quality** HIV counseling and testing in Hawai#i that is **client-centered**, **readily accessible to and focused on** those who are at **high-risk and /or who are HIV infected**, enabling them **to learn of their status** and **link with other** care and prevention **services**.

Goal 1: Provide services of "high quality"

A. Maximize use of existing data collection systems
B. Pilot testing of innovations before system-wide implementation
C. Develop clear professional standards: staff roles, responsibilities and ethics.
D. Strengthen administrative components: staff selection, training, monitoring/quality assurance (QA)
E. Materials review: accuracy, acceptability, appropriateness

Goal 2: Provide services that are "readily accessible"

A. Telephone screening triage system (level of risk, service, need)
B. Increase use of appointment system to allow clients more appropriate access to limited resources and to manage limited resources more effectively

C. Make home testing kits available. Distribution of home test kits by volunteers and others.
D. Increase access to HIV C/T through family planning centers
E. Expand "Opt-out testing" of pregnant women
F. Expand "Opt-out testing" of patients with TB infection or disease.

Goal 3: Provide services that are "client-centered"

A. Solicit consumer input, including "high risk" persons not currently accessing services
B. Separate counseling from testing: assess to determine level of counseling needed, appropriate, desirable for client
C. Offer "opt-out" testing at STD clinic sites
D. Review current marketing and improve materials to promote access to MSM / IDU / TG and others at risk in Hawaiian and other minority populations to recognize special needs
E. Marketing strategies: C/T services are "New and improved"/"Sex without fear"/"Know your status."

Goal 4: Provide services that focus on "those that are at high-risk or who are HIV-infected"

A. Shift access to locations and in settings where more HIV + might be found
B. Expand access to testing services in jails/prisons
C. Commit and reallocate/shift resources to focus on those at high-risk

Goal 5: Provide services that enable high-risk and HIV-infected individuals to "learn their status"

A. Increase use of new/rapid test technologies as available
B. Increase use of OraSure testing
C. Offer option for telephone results
D. Establish option for outreach clients on neighbor islands to get OraSure phone results through O#ahu
E. Develop a procedure to offer preliminary results
F. Expand option for confidential vs. anonymous testing

Goal 6: Provide and strengthen linkages "with other care and prevention services"

A. Improve/strengthen linkages with other organizations providing service to populations at risk, e.g. substance use treatment centers, CBO/ASO, health care and social services, PCRS, etc.
B. Develop and implement updated program of PCRS

C. Develop DOH Policy regarding HIV+ individuals engaging in behaviors that put others at risk without their knowledge or consent

D. Gather information about current HIV treatment protocols in jails/prisons; develop and/or expand HIV/AIDS care and prevention services.

Recommendations for Counseling and Testing

Goal 1: Provide services of "high quality"

A. Data collection: Review and strengthen the data collection and recording systems for counseling and testing of all types.

> **Rationale:** Data is important to monitor the epidemic and counseling/testing services. Data needs to be collected in a manner where it can be used in combination with other HIV/AIDS data. It needs to be collected in a consistent and reliable manner.

B. Pilot test: In general, institute innovations and changes after a pilot test in the most appropriate location. Then expand to other sites as appropriate and feasible.

> **Rationale:** Pilot testing will allow us to make any necessary changes and test protocols and procedures in order to minimize confusion and problems at other locations.

C. Professional standards: Review and clearly define the role and responsibilities of outreach prevention workers/counselor-testers, fixed site counselor/testers and volunteers. Boundaries need to be identified and defined. Professional standards of conduct should be clear.

> **Rationale**: Everyone providing counseling/testing is part of a system and is responsible for maintaining the integrity of that system. Outreach educator/counselors are working in situations and settings that offer the clients opportunities. These situations and settings also pose possible risks for the educator and the system. In the best interests of clients, counselor/testers, and agencies, standards for conduct must be established, maintained and assured. Liability is an issue the DOH and the CBO must also consider.

D. Strengthen counseling and testing service components: Counseling and testing services must include the three important delivery components:

- staff selection and training,
- supervision, with observed sessions,

- a comprehensive quality assurance program

Rationale: These three components ensure that services are accessible and of a high-quality. This will increase in importance, as more individuals and organizations begin to provide services.

E. Materials review: a counseling/testing specialist should review articles, posters, and information for public distribution, for accuracy. Activate the Program Review Panel as required by CDC and named in the grant application. This panel reviews materials for scientific accuracy, the ability to address objectives, the ability to reach the market segment (individuals at high-risk), and for cultural sensitivity and relevance.

Rationale: Inaccurate or inappropriate information may not reach the intended audience, and/or may in fact, cause damage. CDC requires their grantees to have a panel that reviews materials developed by DOH or contracted agencies.

Goal 2: Provide services that are "readily accessible"

A. Phone screening: Phone assessments (using a specific protocol) should be implemented for clients who call for an appointment or more information. Referral to other testing locations could be arranged, which are appropriate to the needs of the client. Hours for making appointments (and thus assessing by phone) may need to be limited to hours when trained staff are available.

Rationale: For some clients, the anonymity of telephone screening may allow a better assessment of risk and need to help determine an appropriate level of counseling. It will allow for better allocation of C/T personnel, as they will focus on those at high-risk. It should allow the scheduling of appointments of an appropriate length, depending on the depth of counseling provided. It may help direct clients to the most appropriate and convenient C/T site and service.

B. Appointment system: Use appointment system for C/T at Diamond Head Clinic and possibly other sites.

Rationale: An appointment system will help make the best use of limited staff, as services would be scheduled more evenly during operating hours. This will help focus resources on those at high-risk. It could be used in conjunction with recommendation A.

C. Volunteers to distribute home test kits and/or provide OraSure testing: Volunteers could be trained to provide OraSure testing or to distribute home test kits. Someone else (not a volunteer)

would provide the results.

Rationale: OraSure and Home test kits are feasible for testing in the field. Having the results come from someone outside of a small community addresses confidentiality concerns. May help promote access to counseling and testing in difficult to reach areas and may increase return rates.

Home testing kits: Provide the option for use of home test kits in rural areas and on neighbor islands. Test results are provided to the client, by the company that sells the kit.
Arrange for one lot number of tests to be distributed to Hawai#i. The home testing company can track some demographic information for us (e.g. the number of kits distributed, the number of tests completed, and the number of positive results.) Other limited demographic information may be available.

Work out a staged pricing system. Instead of paying the full cost for each test, (which would include the lab work and counseling), we could pay for test materials.
plus a cost for each kit used. Work with the home access people to update their resource directory of referrals in Hawai#i. Arrange for distribution to high-risk folks
through the ASOs, by U.S. mail, and by outreach prevention workers or other volunteers. Disadvantages to this type of system need to be considered.

Rationale: Home tests have the advantages of convenience and perhaps increase access to C/T in rural areas and for individuals who want to remain truly anonymous.

D. Family planning clinic sites: Family planning clinics, community health centers or other health service providers could provide HIV tests on a per unit-cost reimbursement basis. This reimbursement could be made available for those wishing the service or specifically to those meeting our high-risk criteria.

Rationale: This service might expand the availability of C/T services in settings where DOH or outreach services are not available or where clients feel it may be more confidential. It would be important to consider the level of risk of the clients that these providers might reach and the cost of providing services this way.

E. "Opt out" counseling and testing for pregnant women: Consider the "opt out" approach to prenatal
screening for pregnant women.

Rationale: Even though only a small number of pregnant women would test positive each year, knowledge of sero-status could prevent transmission of HIV to their babies. Some women may not know they are at risk. If the goal is to have all pregnant women know their HIV status,

this approach may increase the number of women testing. Women would have to be fully informed and given the option to not have the test. The decision to test, needs to meet requirements for "informed consent."

F. "Opt out" counseling and testing for TB positives: Consider the "opt out" approach for certain
individuals that test positive for TB.

Rationale: Although the behavioral profiles of HIV positive individuals and persons with TB in Hawai#i tend to be different, the possibility of co-infection has important ramifications for treatment. "Opt out" testing of those within an appropriate age range or who report a history of possible risk, would improve screening and medical management of TB infection.

Goal 3: Provide services that are "client-centered."

A. Consumer input: To find out what consumers want, ask them. Whenever possible and feasible, survey or interview consumers before changing policies and programs, so that we take into account the consumer perspective. Ask consumers how they would like to access services. Seek input from people who are not accessing prevention services and in particular, those who do not use counseling and testing services. Explore the cultural perceptions of HIV, HIV testing, the health care system, and the cultural stigma of sexuality and disease.

Rationale: Successful programs are designed to meet the needs of consumers. Providers have different perspectives than consumers.

B. Assess client risk for level of counseling/separate counseling from testing. Based on an assessment and the needs of the client, provide minimal counseling to all who present and in-depth counseling to clients at high-risk. Provide all clients with the opportunity to test.

In settings where clients of varying degrees of risk present, develop screening criteria to determine the level of counseling a person needs and desires (triage counseling services). Screening **would not** be used in settings where all clients are presumed to be at high-risk.

In a clinical setting with appointments, the length of counseling sessions should vary according to the type of counseling provided to each client. For "walk-in" clients, counselors should assess what level of counseling the person needs and desires. Since all clients will be tested, any who were previously considered "low risk" (by report) but who test HIV positive, should receive more extensive post-test counseling.

Develop screening criteria by examining our counseling/testing data for people who have

tested positive, and design screening questions. Test screening tool by looking at previous positive cases. Determine if we had asked the proposed screening questions to those who turned out to test positive, how many of the positives would we have missed? Develop an appropriate level of counseling based on the risk assessment. This would include defining basic minimums for counseling.

Rationale: Everyone does not need the same level of counseling. Risk assessment should be client and/or site-specific and could be based on previous test data from that site. For example, if there is higher risk among STD clinic clients than in another site then different screening criteria could be applied. Some clients have had numerous HIV tests with counseling and do not want the counseling again.

C. "Opt out:" Pilot test routine "opt out" HIV testing at STD Clinic. Change STD Clinic procedure to provide HIV test, unless the client specifically declines. Clients must be informed about the test being part of screening and that they can "opt out." Train STD clinicians to provide minimal HIV counseling for STD patients. STD clinic patients will have the option of an anonymous or confidential HIV test.

Analyze demographic data of persons with positive chlamydia tests. Perhaps demographic criteria could help us focus more on those more likely to be at risk.

Rationale: With "opt out" testing in settings serving high-risk individuals, we can test more people who are at risk and find more positives. For example, if STD Clinic clients engage in high-risk behavior with greater frequency, a higher number of HIV positive tests might be detected then in the general population. C/T in some fixed sites/settings may reach high-risk individuals who would not present at a clinic site.

D. Confidential testing: Increase the availability of confidential testing as an option at anonymous test sites.

Rationale: Confidential testing may allow providers the opportunity to contact a client who does not return for a positive test result. The choice of testing anonymously or confidentially would rest with the client. A confidential record system would have to be developed, likely based on the STD model.

E. Recognize/respond to the special needs of Hawaiians and other racial, ethnic, and cultural populations: C/T service providers need an increased awareness of the counseling and testing needs of high-risk individuals in the Hawaiian and ethnic/cultural/minority communities. Services and systems must be sensitive and responsive to these needs.

Rationale: Services tailored to recognize, value and address the needs of particular ethnic,

cultural groups are more effective. Services become more acceptable and accessible for individuals who are at high-risk in these groups.

F. Marketing "New and Improved" counseling/testing: C/T service providers and others should develop a strategy to let communities know that we have improved counseling to recognize and meet their individualized needs.

Rationale: As C/T services become more client-centered, it is important to get the word out to high-risk populations. If they see we are making efforts to meet and address their individual needs they may be more willing to seek services.

G. Marketing "Sex without fear"/ "Know your status:"
Market "Know your status" -- Promote incentives for those at high-risk to know their status. Do needs assessment and marketing of high-risk populations that are not accessing counseling and testing services.

Market "Sex without fear" -- Promote testing to allow "sex without fear" (for two monogamous HIV negative partners). Another important message might be "testing to support developing a safe relationship with another person of the same status." The counselor's role is to inform clients of their status. It is up to the individual to decide to trust their partner (or not). Clients should be encouraged to develop a plan for exceptions, for example:

- have only protected sex with people outside a primary relationship,
- identify which "safer" activities are acceptable to client with people outside a primary relationship,
- address lapses in safety

This campaign must be carefully designed so that it will not be aimed at women (who may not know they are at risk) and others who are at high risk.

Rationale: Although decision-making about safer sex is more complex than knowledge of sero-status alone, it is important to know the HIV status of oneself and one's partner. This helps individuals determine activities that are safest and which protections, if any, should be considered.

Goal 4: Provide services that focus on "those who are at high-risk or who are HIV-infected"

A. Accessing "those at high-risk" and undiagnosed HIV-infected individuals: Focus counseling and testing services at locations where positive individuals are most likely to be found, rather than at locations where many "lower risk" individuals seek services.

Rationale: By focusing services in locations where high-risk individuals are likely to be found, C/T is more likely to serve those at high-risk. *Fewer resources would be directed to those at low to no risk.* For example, instead of sending a DOH counselor to the UH Student Health Services once a week, keep the UH stocked with flyers about counseling/ testing sites, hours and options available on O#ahu.

B. Expand services in prisons: Prison testing should continue and DOH should evaluate the possibilities of expanding services to correctional facilities. Consider the feasibility of "opt-out" testing for patients receiving selected services at OCCC (STD, TB, prenatal, detoxification, other care which may be indicate a profile of the potential for high-risk behavior).

Rationale: Historically, prisons have yielded higher numbers of positive test results than most other sites. There is often a waiting list for HIV testing at Halawa and OCCC, with the current voluntary system. Obtain and evaluate current protocols for screening upon intake, related to STDs (syphilis, chlamydia, gonorrhea, TB , etc). Consider the number of bookings per year and average length of stay.

C. Resources focusing on those at high-risk: Commit or reallocate current resources to focus on those at high-risk.

Rationale: Unless new resources dedicated to C/Tare identified and received, current resources need to shift away from those at low-risk and toward those at high-risk.

Goal 5: Provide services that enable high-risk and HIV infected individuals to "learn of their status"

A. New/Rapid test technologies: As they become available, utilize new/rapid technologies that will allow easier access for high-risk individuals that have never tested, so they can learn their status.

Rationale: New test technologies are expected in the next two years, that will accelerate the availability of preliminary results and improve return rates. Rapid tests do not require cumbersome lab equipment, are transportable and are designed to allow HIV testing and results in the field. Rapid tests would improve the C/T return rate, so that those at high-risk can more easily learn their HIV status. Individuals testing negative would know immediately. Those who initially test positive would still require a confirmatory test, but could be counseled as to how, when and why it is important for them to return for the result. Rapid testing should be piloted before being introduced statewide.

B. OraSure: Consider the feasibility of doing more OraSure (rather than serum) tests, so lab work could be done more often.

Rationale: The two to three week turnaround time for results on neighbor islands may be a deterrent to testing and getting results. If more OraSure tests are provided, this will increase the utility/efficiency of our existing ELISA test runs. Shipping procedures from neighbor islands need review, to ensure a fit with test schedules at the state lab. The cost of shipping is a consideration.

C. Phone test results: Provide clients the option of calling in for their HIV test results. Develop a system that ensures a way to identify the caller and maintain confidentiality. For clients with positive test results, develop strong links to follow-up prevention and care services as needed, desired and appropriate.

Rationale: Studies in other location show that the phone-in option increases the rates of return. Clients are more likely to learn their test results.

D. O#ahu phone results for neighbor island counseling and testing services: Develop an option that allows counselor/testers and outreach workers on neighbor islands and in rural areas to provide pretest counseling and the OraSure test. Clients could choose to call into the clinic on O#ahu for results via telephone.

Rationale: Results coming from someone outside of a small community may help address concerns about confidentiality. Easier access to results may serve to promote counseling and testing in difficult to reach areas.

E. Provide preliminary HIV test results

Decisions need to be made and protocols developed to provide positive preliminary results and information about confirmatory testing. Careful consideration and thought will need to go into designing protocols for how you give people preliminary results for those who need confirmatory test results, so as not to unduly alarm people. The development of a preliminary test results protocol will help prepare us for the time when rapid testing becomes available.

Rationale: A two to three week turn-around time for clients to get HIV test results on neighbor islands and the delay on O#ahu may have a negative effect on return rates. Providing preliminary results will allow clients with negative results to have access in a more timely fashion. Clients that need confirmatory test results will be told of this when they get their preliminary results. Preliminary results could be available within three days of testing.

Goal 6: Provide and strengthen linkages "with other care and prevention services"

A. Linkages: Create strong linkages between the counseling and testing system and other components of the prevention system, care services, including partner counseling and referral services (PCRS). Links need to be reviewed for all settings in which C/T takes place and appropriate protocols developed.

> **Rationale:** Counseling and testing will put providers in contact with individuals who are at high-risk or who test positive for HIV. As the number of individuals providing counseling/testing increases, and as testing occurs in more diverse settings, we must be certain that linkages to support services are available.

B. Partner Counseling and Referral Services (PCRS): Hawai#i's procedures and protocols for Partner Counseling and Referral Services (PCRS), in both traditional and outreach settings, need review and development. PCRS should be strengthened and implemented in a way that meets CDC guidelines.

> **Rationale:** PCRS offers a client who tests positive with options, support and assistance to inform partners. Services are voluntary, and are provided in ways that meet the client's needs while preserving confidentiality. These services offer individuals who may have been exposed to HIV infection, the opportunity to learn their own HIV status and choose in an informed manner, appropriate prevention and care options. PCRS protocols should be implemented in all settings where individuals learn of their HIV positive status including physician's offices, clinics and outreach.

C. HIV treatment in prison: Ask for and review treatment protocols. Assess the current level of care provided to inmates with HIV/AIDS in correctional facilities. Facilities that do not have clear policies can be supported to develop them. With client consent, ASOs should advocate on behalf of HIV positive inmates with the supervisor of the medical unit.

> **Rationale**: It is in the best interest of the patient and the facility to ensure that inmates with HIV/AIDS have access to adequate medical care while incarcerated. Consider primary mission of jails and prisons, which is public safety. Also consider challenges of protecting patient rights, safety and confidentiality.

D. "Recalcitrant individuals"/ willful transmission policies: DOH/SAPB should develop policies and guidance concerning "recalcitrant individuals" who do not disclose status and who put others at risk, endanger others by their disregard, or who willfully transmit HIV to others.

> **Rationale:** This complex, charged issue requires a reasonable policy, developed in a pro-active manner. Existence of clear policies before the fact may circumvent the introduction of "rogue legislation" arising out of an emotional response to an "emergent incident."

Background information

Objectives for the counseling and testing system in Hawai#i

1. Increase the number of individuals at high-risk who are accessing C/T services.
2. Increase return rate.
3. Integrate options for counseling/testing into long-term prevention programs in community-based services (HIV, substance abuse, prisons, domestic violence, etc.)
4. Strengthen linkages to care and prevention services for persons testing positive.
5. Increase number/percentage of "at high-risk negative" clients tested who enter/receive longer-term behavior change intervention.
6. Increase numbers of skilled peer counselors providing counseling/testing services.
8. Achieve high level of client satisfaction with services.
9. Strengthen partner counseling and referral services to notify exposed individuals.

Characteristics of a counseling and testing system that would allow us to meet objectives

- C Client-centered
- C Peer-based
- C Culturally and linguistically appropriate.
- C Sensitive to focus population.
- C Accessible in terms of time, location and geography.
- C Results provided in a timely manner.
- C Free / anonymous / confidential.
- C Well-trained staff to increase quality of service.
- C Linked with a continuum of services (prevention, care, PCRS).
- C Integration / collaboration with community agencies - including long term intervention.
- C Responsive to changing technologies, research findings on how to reach and work with communities and individuals at high-risk.
- C Efficient, cost effective.
- C Provides data for monitoring and evaluation.

Counseling and testing strategic plan timeline

Underway	Now (6/99-12/99)	2000	2001
Emphasize client-centered approach	Solicit consumer input (include those at high-risk not accessing services) *	Assess current marketing strategies	Expand C/T services to family planning clinics
Increase services to those at high risk	Develop system to provide preliminary results* ***	Screen for level of risk to separate testing from counseling	Market: "New and improved," "Sex without fear," "Know your status"
Implement new technologies; increase use of OraSure *	Offer telephone results* ***	Develop appointment system	Further develop PCRS services
Expand option for confidential vs anonymous testing	Gather information about jail/prison protocols in place *	Implement telephone screening and triage procedure	Develop DOH policy: willful or negligent transmission of HIV
Maximize use of data collection systems to help assess needs	Develop and implement quality assurance (QA) monitoring program	Incorporate rapid test technologies	Expand opt-out testing to include pregnant women and TB + individuals
Expand testing services to populations in need, including jails and prisons	Clarify roles/responsibilities of staff in plan, ethics training	Increase availability of home testing kits, use volunteers or others to distribute	
Increase promotion of HIV C/T to Native Hawaiian and other "high risk" minority populations (MSM, TG, IDU)	Develop option for neighbor island results to be given by telephone from O#ahu	Evaluate HIV/AIDS services in jails and prisons, develop linkages for improved services	* Five priorities for implementation
Improve and strengthen linkages to other prevention and care organizations	Implement "opt-out" testing at STD Clinic		*** Top two priorities for immediate implementation

Linkages

Linkages with Department of Education (DOE)

Progress (July 1998 - June 1999)
The DOE was in process of changing its administrative rules regarding protection of students from discrimination. SAPB staff were instrumental in initiating and garnering support to add to these proposed changes "sexual orientation" to the classes of students protected from harassment and discrimination in the public school system. Interested members of the Youth At-Risk Advisory Committee, outreach workers, administrators of community-based organizations and affected youth testified at the Board of Education meeting in February 1999, when they considered these revisions to the administrative rules. Public hearings are pending before the changes are finalized.

A representative from the DOE is appointed to the PCPG.

Collaboration with agencies serving youth

Progress (July 1998 - June 1999)
Based on a discussion at the October 1998 PCPG meeting, there was a consensus that the PCPG wanted to encourage collaboration and linkages between those organizations doing HIV prevention and existing organizations and networks that serve high risk youth. The collaboration was to be in the form of providing technical assistance and training to build the youth serving agencies' capacity to address sexuality issues and HIV prevention with youth at risk for HIV. The collaboration would lead to better coordination of resources and HIV prevention services and a stronger youth network. The PCPG agreed and the HIV prevention contracts state that there must be collaborative, capacity-building services between contracted agencies and organizations that serve high risk heterosexual male and female youth.

A membership position for 2000 has been established for a youth at-risk (14-21). The PCPG recommended that an incentive be available to support this member, if needed. Previously, the PCPG has not had a representative from this population.

Linkages between primary prevention and secondary prevention[2]

Progress (July 1998 - June 1999)

As a result of recommendations made by the PCPG in 1998, HIV prevention contracts currently require that prevention programs provide secondary prevention messages and that contractors use some of their public information funds to convey secondary prevention information.

In 1998, the Prevention Community Planning Group recommended that secondary prevention guidelines be developed for use by primary prevention workers. As a result, a committee was formed and met for the first time in March 1999. At the second meeting, they changed their name from "Secondary Prevention Committee" to "Committee to Strengthen Linkages Between Primary and Secondary Prevention." Members from Hawai#i HIV Care Services Community Planning Group were invited to attend this committee and received the minutes from the two meetings of this committee.

The PCPG approved the following guidelines about secondary prevention for primary prevention workers.

[2] **Primary prevention** prevents **new** cases of HIV.
Secondary prevention aims to stop or slow the progression of HIV.

Guidelines for primary prevention workers to provide secondary prevention

- Convey messages about
  - Importance of knowing one's HIV status
  - Various options of counseling and testing, and how, when, and where to access counseling and testing
  - Importance of early treatment
  - Reassurance that person is not alone, that support is available
- Keep up-to-date resource list and be knowledgeable about support services
- Provide current information on referrals and resources
  - If they are HIV+
    - Referral to case management options
    - Referral to HSPAMM and to other medical care.
    - Be familiar with *A Healing Path.*
    - Be familiar with pamphlets and lists of services that change frequently (such as clinical trials, support groups).
    - SAPB's *HIV/AIDS resource directory for organizations in Hawai#i*
    - Support around telling one's partner
- Develop a strong collaborative relationship with intake workers and case managers.

In the care services contracts in 1999, ASOs were asked to include primary prevention services for HIV + clients. The Committee to Strengthen Linkages Between Primary and Secondary Prevention began discussion about developing primary prevention guidelines for care workers/secondary prevention workers.

A PCPG member represents prevention at the Care Community Planning Group meetings. Also the PCPG has an appointed position of a representative from the AIDS Community Care Team (ACCT, a consortium of care providers).

Needs

The Committee to Strengthen Linkages Between Primary and Secondary Prevention also identified several needs for

* more awareness about what prevention workers are doing related to secondary prevention and what case managers are doing related to primary prevention,

* more information about how ASOs coordinate prevention and care services,

* more communication between prevention workers and care workers at the organizational level,

* more input from case managers,

* viewing the client's needs holistically, and noting the various points of access to reach people.

To satisfy these needs, the Committee to Strengthen Linkages Between Primary and Secondary Prevention discussed a few possible strategies, but these were not finalized. Several committee members volunteered to review and further develop these strategies:

1. Develop processes to encourage ASOs and other contractors to review how their organizations coordinate prevention and care.

2. Encourage input from consumers about the effectiveness of current secondary prevention measures.

3. Coordinate some type of meeting or forum.

In addition, Darrel Higa from the SAPB DOH conducted a small study of HIV positive individuals who attended a PLUS weekend (Positively Living for Us, a seminar for people who are newly diagnosed and their friends and partners). The short survey asked who told them about their positive HIV status (e.g., physician, DOH counselor) and what this individual said or did that was helpful or unhelpful; the length of time from finding out they were positive until they saw a doctor and sought assistance from an HIV/AIDS related agency; and reasons for seeing doctor or ASO. He presented the results to the Committee to Strengthen Linkages Between Primary and Secondary Prevention in May 1999.

As a result of recommendations in last year's plan, all state and federal HE/RR contracts will continue to state that all HIV prevention programs include strategies, activities, and interventions as well as public information messages to encourage individuals *at risk for HIV* to seek counseling and testing and for HIV seropositive individuals to access medical care, AIDS care providers, HIV case management services and other related health services. HIV prevention clients will be encouraged to find out their serostatus if unknown in order to gain benefits of early intervention and prevention of HIV transmission. Contractors that provide prevention services will publicize all counseling and testing services offered both by the agency and by the DOH, including sites and hours of service. Such strategies, activities, and interventions include using a portion of public information funds, providing outreach, providing skills building workshops, and cultivating community development and participation to encourage those at risk to obtain counseling and testing at STD/HIV clinics, private clinics, and ASOs.

All state and federal HE/RR contracts will continue to state that all individuals who test positive for HIV receive information on treatment and resources, and that clients link up with health and social services. Contractors will ensure that HIV positive clients are aware of the availability and importance of health and social services. These services include AIDS care providers, HIV case management and health

services, including HSPAMM (Hawai#i Seropositivity and Medical Management).

Hawai#i is fortunate to have a state-funded HSPAMM program which provides, through participating providers, a history, physical, and immune function tests every six months to individuals with HIV. The person with HIV is monitored throughout the course of the infection and the physician can intervene early to minimize viral replication and prevent opportunistic infections, thereby prolonging and enhancing quality of life. The HDAP program provides HIV treatment drugs to eligible individuals. The H-COBRA program assists people to retain health insurance after they have left employment due to HIV.

HSPAMM client records from 1996 and 1997 were reviewed to evaluate the linkages between primary and secondary prevention services and found that 81 clients were referred by DOH test sites, 77 by private physicians, other 32, blood bank 3, and blank 7. The majority of people enrolling in the program have done so in the same or the next year following their first positive HIV test. HSPAMM doctors have all received a state of the art HIV treatment manual from HSPAMM. HSPAMM sends physicians treatment updates and CDC recommendations. Any client who enrolls with HSPAMM receives updated care information through their doctor.

Linkages with mental health

Progress (July 1998 - June 1999)
In 1998, the PCPG created a position for a mental health services representative, which was filled until the member moved out of state in late summer 1999. The July 1999 PCPG meeting included a presentation about mental health and HIV. The mentally ill are a concern and a hidden population.

2000 Recommendations for mental health

The PCPG will recruit for the mental health services member position. The PCPG will have a presentation about HIV prevention among the mentally ill.

Linkages with substance use

Staff from Drug Addiction Services of Hawai#i (DASH) and Community Health Outreach Work Project (CHOW) which provides needle exchange statewide are involved in some of the PCPG committees (counseling and testing, needs assessment, evaluation). There is an injection drug use position on the PCPG. DASH and CHOW provide HIV prevention services to substance users. HIV prevention outreach workers refer clients who present with substance use issues to DASH and CHOW. Some state HIV prevention funds are available through the DOH to provide substance abuse treatment for injection drug users. One known gap in Hawai#i is a lack of substance abuse treatment on

some neighbor islands.

2000 Recommendations for substance use

The PCPG will form a committee or task force to address substance use linkage issues.
The task force/committee will educate the PCPG about substance use linkage issues.

Coordination of HIV Prevention Services and Programs

SAPB and the CPG will work together to facilitate coordination and collaboration among public and nongovernmental agencies involved with HIV prevention. SAPB staff and CPG members will participate in monthly and quarterly meetings related to HIV prevention held by community-based organizations. Such meetings include AIDS Community Care Team (ACCT), Transgender Education and Outreach Project (TGEOP), Harm Reduction Coalition, Women's Coalition, the HIV Subcommittee of the Red Cross, and the community consortia of AIDS-related services (MARS - Maui, KARS - Kauai, EHARS - East Hawai#i). HE/RR staff will also collaborate with the Office of Family Planning for Women's Health Month and World AIDS Day.
SAPB and CPG will continue to foster linkages within DOH with Maternal Child Health, Office of Family Planning, School Health, Alcohol and Drug Abuse Division among others and with other state departments such as Human Services, Corrections, and Education.
SAPB staff will attend and facilitate the quarterly meetings of the Governor's Committee on HIV/AIDS (GCHA) in order to promote the exchange of information related to the HIV Prevention and Care Services CPGs and other HIV-related coalitions. DOH will also continue to collaborate with the Department of Education (DOE) in initiatives related to HIV prevention education for school-aged youth, such as providing training to teachers on how to improve support for sexual minority youth. DOH will collaborate with DOE regarding public information activities intended for teens through such events as World AIDS Day and the international AIDS memorial observance. DOH will continue to coordinate the AIDS Educators' Quarterly meetings which bring together educators from organizations statewide to foster networking and information exchange among PCPG, DOH, and other community HIV programs providing HIV prevention services to at-risk populations.

Abbreviations

ACCT	AIDS Community Care Team
ADAD	Alcohol and Drug Abuse Division
AED	Academy for Educational Development
API	Asian and Pacific Islander
ASO	AIDS service organization (a community-based organization)
ATS	Alternative testing sites
CAC	Community advisory committee
CAG	Community advisory group
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CHOW	Community Health Outreach Work Project, that provides needle exchange

	services statewide
CP	Community planning
CPG	Community Planning Group
CT or C/T	Counseling and testing
CTS	Counseling and Testing Sites
DASH	Drug Addiction Services of Hawai#i
fDIS	Disease intervention specialist
DOH	Hawai#i Department of Health
"Epi"	Epidemiologic
GayMAP	Gay Men's AIDS Prevention
GCHA	Governor's Committee on HIV/AIDS
HCOBRA	The H-COBRA program assists people to retain health insurance after they have left employment due to HIV.
HDAP	HIV Drug Assistance Program
HSPAMM	Hawai#i Seropositivity and Medical Management Program[3]
IDU	Injection drug user
MSM	Men who have sex with men
NGIMSM	Non-gay-identified men who have sex with men
OCCC	O#ahu Community Correctional Center
PCPG	Hawai#i HIV Prevention Community Planning Group
RFP	Request for Proposal
SAPB	STD/AIDS Prevention Branch of the Hawai#i Department of Health
STD	Sexually Transmitted Disease
TG	Transgender, transgendered
TGEOP	Transgender Education and Outreach Project
UH	University of Hawai#i

[3]The state-funded **HSPAMM** program provides, through participating providers, a history, physical, and immune function tests every six months to individuals with HIV. The person with HIV is monitored throughout the course of the infection and the physician can intervene early to minimize viral replication and prevent opportunistic infections, thereby prolonging and enhancing quality of life. The **HDAP** program provides HIV treatment drugs to eligible individuals.

Evaluation of the Hawai#i HIV Prevention Community Planning Group Survey Results 1999, 1998, and 1997						
CPG members were asked to state whether they agreed or disagreed with these statements. "1" was strongly disagree and "5" was strongly agree.						
Statement	**1999**		**1998**		**1997**	
	Average (Mean)	**Percent agree[4]**	**Average (Mean)**	**Percent agree**	**Average (Mean)**	**Percent agree**
Received timely notice of meetings	4.56	89	4.59	94.1	3.83	63.2
Member should let the group know if they have a conflict of interest when they are discussing an issue.	4.55	85	not asked in 98		not asked in 97	
Member shouldn't vote on issue if they have direct conflict of interest	4.55	90	not asked in 98		not asked in 97	
Committee structure is effective way to do the work of community planning	4.53	94.7	4.35	82.3	not asked in 97	
Community planning has influenced allocation of resources	4.42	100	3.97	70.6	3.11	47.3
Minutes provide adequate information	4.40	90	4.41	94.2	not asked in 97	

[4] Percent agree is the percent of answers above 3 on the five-point scale.

Statement	1999		1998		1997	
	Average (Mean)	Percent agree[5]	Average (Mean)	Percent agree	Average (Mean)	Percent agree
Committee structure should continue next year	4.37	89.4	4.35	76.4	not asked in 97	
Technical assistance useful to me as CPG member (eval, na, counseling and testing, epi)	4.26	89.4	not asked in 98		not asked in 97	
Committees are set up to encourage participation	4.24	82.4	3.94	76.5	not asked in 97	
Meetings are convenient	4.23	75	4.29	82.4	3.58	52.7
CPG influences prevention programs	4.20	90	4.32	94.2	3.37	52.6
Prioritization based on available evidence	4.16	84.2	3.91	76.5	2.95	42.1
Received adequate orientation	4.15 (n=13)	84.6	3.56 (n=8)	50	2.00 (n=7)	14.3
CPG meetings encourage participation	4.15	75	4.15	88.3	3.32	42.1
I share CPG info w/ my agency /community	4.11	79	3.59	41.2	4.00	63.1

[5] Percent agree is the percent of answers above 3 on the five-point scale.

Statement	1999		1998		1997	
	Average (Mean)	Percent agree[6]	Average (Mean)	Percent agree	Average (Mean)	Percent agree
Members listen to and are sensitive to differences	4.10	80	4.35	82.3	3.44	42.1
Meetings run efficiently by co-chair or facilitator	4.10	80	4.47	94.1	2.95	31.6
CPG reflects HIV epidemic in our planning area	4.05	80	3.76	64.7	3.26	47.4
Members understand their roles and responsibilities	4.00	80	3.79	70.6	3.56	57.9
Terms, concepts are clearly defined so all understand	3.90	70	3.68	64.7	3.21	42.1
Adequate time for discussion before making decisions	3.85	75	3.62	52.9	2.26	21
CPG members have not used meetings to further own personal or organizational interests	3.80	65	3.24	41.2	2.89	26.4
HIV funds have been distributed fairly	3.28	44.4	not asked in 98		not asked in 97	
Conflict of interest has negative effect on decisions made by CPG	3.17	44.5	not asked in 98		not asked in 97	

[6] Percent agree is the percent of answers above 3 on the five-point scale.